TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
SUBCHAPTER b: ASSISTANCE PROGRAMS

PART 120
MEDICAL ASSISTANCE PROGRAMS

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Section

AUTHORITY: Implementing Articles III, IV, V and VI and authorized by Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V and VI and 12-13].

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October 30, 1998; amended at 23 Ill. Reg. 2381, effective January 22, 1999; amended at 23 Ill. Reg.11301, effective August 27, 1999; amended at 24 Ill. Reg. 7361, effective May 1, 2000; emergency amendment at 24 Ill. Reg. 10425, effective July 1, 2000, for a maximum of 150 days; amended at 24 Ill. Reg. 15075, effective October 1, 2000; amended at 24 Ill. Reg. 18309, effective December 1, 2000; amended at 25 Ill. Reg. 8783, effective July 1, 2001; emergency amendment at 25 Ill. Reg. 10533, effective August 1, 2001, for a maximum of 150 days; amended at 25 Ill. Reg. 16098, effective December 1, 2001; amended at 26 Ill. Reg. 409, effective December 28, 2001; emergency amendment at 26 Ill. Reg. 8583, effective June 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 9843, effective June 26, 2002; emergency amendment at 26 Ill. Reg. 11029, effective July 1, 2002, for a maximum of 150 days; emergency amendment at 26 Ill. Reg. 15051, effective October 1, 2002, for a maximum of 150 days; amended at 26 Ill. Reg. 16288, effective October 25, 2002; amended at 27 Ill. Reg. 4708, effective February 25, 2003; emergency amendment at 27 Ill. Reg. 10793, effective July 1, 2003, for a maximum of 150 days; amended at 27 Ill. Reg. 18609, effective November 26, 2003; amended at 28 Ill. Reg. 4701, effective March 3, 2004; amended at 28 Ill. Reg. 6139, effective April 1, 2004**;** emergency amendment at 28 Ill. Reg. 6610, effective April 19, 2004, for a maximum of 150 days; emergency amendment at 28 Ill. Reg. 7152, effective May 3, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 11149, effective August 1, 2004; emergency amendment at 28 Ill. Reg. 12921, effective September 1, 2004, for a maximum of 150 days; amended at 28 Ill. Reg. 13621, effective September 28, 2004; amended at 28 Ill. Reg. 13760, effective October 1, 2004; amended at 28 Ill. Reg. 14541, effective November 1, 2004; amended at 29 Ill. Reg. 820, effective January 1, 2005; amended at 29 Ill. Reg. 10195, effective June 30, 2005; amended at 29 Ill. Reg. _____, effective September 30, 2005.

SUBPART A: GENERAL PROVISIONS

Section 120.1 Incorporation by Reference

Any rules or regulations of an agency of the United States or of a nationally recognized organization or association that are incorporated by reference in this Part are incorporated as of the date specified, and do not include any later amendments or editions.

(Source: Added at 13 Ill. Reg. 3908, effective March 10, 1989)

SUBPART B: ASSISTANCE STANDARDS

Section 120.10 Eligibility For Medical Assistance

a) Eligibility for medical assistance exists when a client meets the non-financial requirements of the program and the client's countable nonexempt income (Sections 120.330 and 120.360 is equal to or less than the applicable Medical Assistance - No Grant (MANG) standard and for AABD MANG, countable nonexempt assets are not in excess of the applicable asset disregards (Section 120.380).

b) For AABD MANG, the client's countable income and assets include the client's nonexempt income and assets and the nonexempt income and assets of all persons included in the Medical Assistance standard. The client's responsible relative(s) living with the child must be included in the standard. The client has the option to request that a dependent child under age 18 in the home who is not included in the MANG unit be included in the MANG standard.

c) For TANF (Temporary Assistance for Needy Families) MANG, the client's countable income includes the client's nonexempt income and the nonexempt income of all persons included in the Medical Assistance standard. The client's responsible relative(s) living with the child must be included in the standard. The client has the option to request that a dependent child under age 18 in the home who is not included in the MANG unit be included in the MANG standard.

d) For AABD MANG, if the client's countable nonexempt income is greater than the applicable MANG standard and/or countable nonexempt assets are over the applicable asset disregard, the client must meet the spenddown obligation determined for the applicable time period before becoming eligible to receive medical assistance.

e) For TANF MANG, if the client's countable nonexempt income is greater than the applicable MANG standard, the client must meet the spenddown obligation determined for the applicable time period before becoming eligible to receive medical assistance.

f) A one month eligibility period is used for clients receiving care in an intermediate care facility (ICF) or skilled nursing facility (SNF) or in a Department of Human Services facility. Nonexempt income and nonexempt assets over the asset disregard are applied toward the cost of care on a monthly basis.

g) Newborns

    1) When the Department becomes aware of the birth of a child to a recipient of a TANF or AABD grant or related medical assistance or medical assistance due to the mother's pregnancy, the child shall be deemed to have applied for medical assistance only, without written request, if the mother had been receiving TANF or AABD related medical assistance or medical assistance due to her pregnancy on the date of birth of the child.

    2) The newborn shall be eligible to receive medical assistance for a period of

time as determined in Section 120.400.

(Source: Amended at 24 Ill. Reg. 7361, effective May 1, 2000)

Section 120.11 MANG(P) Eligibility

a) Pregnant Women Eligible for MANG(P)
   1) Eligibility for medical assistance exists for a pregnant woman of any age who does not qualify as mandatory categorically needy (42 USC 1396a(a)(10)(A)(i)) who meets the following eligibility requirements:
      A) cooperation in establishing eligibility as described in Section 120.308;
      B) residency as described in Section 120.311; and
      C) whose countable monthly income does not exceed the MANG(P) Income Standard (see Section 120.31).
   2) The pregnant woman shall be eligible to receive medical assistance until 60 days following the last day of pregnancy. The 60 day medical coverage continues through the last day of the calendar month in which the 60 days period ends. The 60 day medical coverage period shall be provided for all women determined eligible for medical assistance under subsection (a)(1) of this Section including women who are no longer pregnant at the time of application, but were pregnant at any time during the three calendar months preceding the month in which the application was received. A woman who meets the requirements of this Section is eligible regardless of whether the pregnancy ended as a result of a birth, miscarriage or abortion and regardless of whether she signed an adoption agreement.
   3) When a pregnant woman is determined eligible for medical assistance under subsection (a)(1) of this Section, income changes occurring after the eligibility determination are not considered through the 60 day postpartum period following the last day of pregnancy.

b) Children Under Age 19 Eligible for MANG(P)
   1) Eligibility for medical assistance exists for children under age 19 who do not qualify as mandatory categorically needy (42 USC 1396a(a)(10)(A)(i)) who meet the following eligibility requirements:
      A) cooperation in establishing eligibility as described in Section 120.308;
      B) citizenship/alienage status as described in 120.310;
      C) residency as described in Section 120.311; and
      D) whose countable monthly income exceeds the MANG(C) or MANG(AABD) income standards (Sections 120.20 and 120.30) but does not exceed the MANG(P) income standard (see Section 120.31).
   2) Children under age 19 shall be eligible to receive medical assistance under subsection (b)(1) of this Section for a period of time as determined in Section 120.400.
   3) When the Department becomes aware of the birth of a child or children to a woman determined eligible under subsection (a)(1) of this Section while she was eligible, the child or children shall be deemed to have applied and been

found eligible for medical assistance under subsection (b)(1) of this Section, without written request. The child or children shall be eligible to receive medical assistance for a period of time as determined in Section 120.400.

(Source: Amended at 24 Ill. Reg. 7361, effective May 1, 2000)

Section 120.12 Healthy Start - Medicaid Presumptive Eligibility Program For Pregnant Women

The purpose of the Healthy Start - Medicaid Presumptive Eligibility (MPE) Program is to encourage early and continuous prenatal care to low income pregnant women who otherwise may postpone or do without such care. Presumptively eligible pregnant women shall receive ambulatory prenatal care before completing an application for medical assistance under the State plan at the local Public Aid Office.

a) Eligibility: To be eligible for the Healthy Start - Medicaid Presumptive Eligibility Program, the woman must have:
   1) a medically verified pregnancy; and
   2) family income not exceeding 133% of the Federal Poverty Level.

b) Qualified providers shall make all determinations as to eligibility - the MPE Program (42 U.S.C. 1396).

c) The presumptive eligibility period shall be the period that:
   1) begins with the date on which a qualified provider determines, on the basis of preliminary information, that the family income does not exceed 133% of the Federal Poverty Level; and
   2) ends with (and includes) the earlier of:
      A) the day on which a determination is made with respect to the eligibility of the woman for medical assistance under the State plan; or
      B) in the case of a woman who does not file an application by the last day of the month following the month during which the provider makes the determination, such last day.

d) Duties of the State agency, qualified providers, and presumptively eligible pregnant women.
   1) The Department shall provide qualified providers with:
      A) such forms as are necessary for a pregnant woman to make application for medical assistance under the State plan; and
      B) information on how to assist such women in completing and filing such forms.
   2) A qualified provider who determines that a pregnant woman is presumptively eligible for medical assistance under a State plan shall:
      A) notify the Department of the determination within 5 working days after the date on which the determination is made; and
      B) inform the woman at the time the determination is made that she is required to make application for medical assistance under the State plan by no later than the last day of the month following the month during which the determination is made.
   3) A pregnant woman who is determined by a qualified provider to be presumptively eligible for medical assistance under a State plan shall make application for medical assistance under such plan by no later than the last day of the month following the month during which the determination is

made.

e) Ambulatory prenatal care consists of all outpatient medical care covered by the State plan.

(Source: Added at 15 Ill. Reg. 14240, effective September 23, 1991)

Section 120.14 Presumptive Eligibility for Children

a) A child younger than 19 years of age may be presumed eligible for medical assistance under this Part if all of the following apply:

1) an application for medical benefits has been made on behalf of the child;

2) the child is a resident of Illinois as described in Section 120.311;

3) the child is not an inmate of a public institution as described in Section 120.318(a);

4) the child's family's monthly income, as stated on the application, is at or below 133 percent of the poverty level;

5) the State employee who registers the application has no information that the child is not a U.S. citizen or a qualified non-citizen as described in Section 120.310 or 89 Ill. Adm. Code 118.500; and

6) the child has not been presumed eligible under this Part 120 or 89 Ill. Adm. Code 118 or 125 within the past 12 months.

b) Entities qualified to make a determination of presumptive eligibility include State employees involved in enrolling children in programs under this Part 120 or 89 Ill. Adm. Code 118 or 125.

c) The presumptive eligibility period begins on the date of application.

d) The presumptive eligibility period ends on the date the State's determination of the child's eligibility under this Part 120 or 89 Ill. Adm. Code 118 or 125 is updated in the data system.

(Source: Added at 28 Ill. Reg. 13621, effective September 28, 2004)

Section 120.20 MANG(AABD) Income Standard

a) The monthly countable income standard is 100 percent of the Federal Poverty Level Income Guidelines, as published annually in the Federal Register, for the appropriate family size.

b) A client receiving care in a public tuberculosis hospital is not considered to be receiving long term care. Such a client's financial eligibility for MANG is determined by use of the Aid to the Aged, Blind or Disabled MANG (AABD) Income Standard.

c) The MANG (AABD) Income Standard is used in the determination of financial eligibility for MANG of a client living in a residential home or facility which is not licensed as a medical care facility or as a sheltered care facility. The cost of maintenance and/or care in such a facility is not an allowable medical expense. Regardless of the amount the client may be paying for care and/or maintenance in the facility, the client's nonexempt income and assets in excess of the MANG (AABD) Standard are considered available for payment for medical care not provided in the facility.

d) MANG

1) A recipient residing in a Department of Human Services (DHS) State psychiatric hospital or developmental center is allowed $30 per month in lieu of any other MANG standard.

2) As soon as MANG (AABD) clients become residents of a DHS facility (see subsection (d)(1) of this Section), a skilled nursing facility, an intermediate care facility, or other facility, their eligibility for MANG is determined separately from persons remaining in the home.

3) When eligibility is based on being temporarily discharged from a DHS facility (see subsection (d)(1) of this Section) for the purpose of obtaining medical care in a general hospital, the amount which the recipient is obligated to pay DHS for care and maintenance is to be allowed in addition to the $30.

4) Clients in a long term facility are allowed deductions from their non-SSI income to meet the needs of their community spouse, dependent family members and dependent children under the age of 21 years who do not reside with the community spouse. Family members include dependent children under the age of 21 years, dependent adult children, dependent parents or dependent siblings of either spouse who reside with the spouse in the community. To calculate the amount of non-SSI income to be deducted, use the:

A) Community Spouse Maintenance Needs Allowance (as described at Section 120.61) if the deduction is for a spouse in the community;

B) Family Maintenance Needs Allowance (as described in Section 120.61) if the deduction is for dependent family members residing with the community spouse; and

C) Temporary Assistance for Needy Families (TANF) cash grant standard if the deduction is for dependent children under the age of 21 years who do not reside with the community spouse.

(Source: Amended at 26 Ill. Reg. 16288, effective October 25, 2002)

Section 120.30 MANG(C) Income Standard

Number In Family	*Monthly Net Income*
1	283
2	375
3	508
4	558
5	650
6	733
7	767
8	808
9	850
10	900
11	942
12	992
13	1042
14	1100
15	1158
16	1217
17	1283
18	1350

a) If the number in the household unit exceeds the number provided above, add $67 for each additional person.

b) MANG(C) is available for a pregnant woman, of any age, who would be eligible for TANF or MANG(C) if the child had already been born. The pregnant woman and her spouse's income are combined and compared to the MANG standard for three persons.

c) If the case includes adults only, the MANG standard for one adult is $283. The standard for two adults is $375. An unborn child is counted as a family member.

d) When a child has earmarked income, other than State Supplemental Income (SSI), and the parent does not want this income applied to total family needs, the child is not to be included in the assistance unit. The family size used in the application of the MANG(C) Income Standards shall be reduced by one for each such child determined ineligible on this basis.

e) When financial eligibility for MANG(C) is being determined for one child only, the income of the child in excess of $283 a month is considered available to pay toward the child's medical expenses.

f) If eligibility is being determined for more than one child, the MANG(C) Standard for number of people shall be used.

(Source: Amended at 22 Ill. Reg. 19875, effective October 30, 1998)

Section 120.31 MANG(P) Income Standard

a) MANG(P) is available to pregnant women and to children under age 19 who do not qualify as mandatory categorically needy (42 USC 1396a(a)(10)(A)(i)) whose non-exempt countable income does not exceed the MANG(P) income standard. If the household's countable monthly income exceeds the appropriate MANG(P) standards, eligibility for MANG(P) does not exist. The MANG(P) income standards are as follows:
   1) The MANG(P) income standard shall be 200 percent of the current Federal Poverty Level Income Guidelines, as published annually in the Federal Register, for pregnant women and for infants born to women eligible for and receiving medical assistance on the date of the child's birth, including women determined eligible for the date of birth pursuant to subsection (e)(4) of this Section.
   2) The MANG(P) income standard shall be 133 percent of the current Federal Poverty Level Income Guidelines, as published annually in the Federal Register, for all other children under age 19.

b) MANG(P) is available for a pregnant woman, of any age, whose countable monthly income for the household does not exceed the MANG(P) income standard. If the pregnant woman is married and her spouse lives with her, her pregnancy does not make her spouse eligible for MANG(P). The pregnant woman and her spouse's income are combined and compared to the MANG(P) standard for the number of persons in the family even though only the pregnant woman is eligible to receive MANG(P). An unborn child is counted as a family member.

c) MANG(P) is available for children under age 19 whose countable monthly income for the household does not exceed the appropriate MANG(P) income standards.

d) When financial eligibility for MANG(P) is being determined for a child under age 19, the household's income is combined and compared to the MANG(P) income standard for the family size, including unborn children.

e) When financial eligibility for MANG(P) is being determined for a woman who meets the requirements for MANG(P), income is considered in the following manner:
   1) Income is considered for the month of application. When eligibility exists for the month of application, MANG(P) coverage is authorized beginning with the month of application. Income changes occurring after the month of application are not considered through the 60 day period following the last day of pregnancy.
   2) Income is considered for the month following the month of application when the woman is income ineligible for the month of application. If eligibility exists for the month following the month of application, MANG(P) coverage is authorized beginning with the month following the month of application. Income changes occurring after the month following the month of application are not considered through the 60 day period following the last day of pregnancy.

3) When the case is income ineligible for the month of application and the month following the month of application, financial eligibility is determined under Sections 120.10 and 120.60.

4) When determining income eligibility for a backdated month (up to three months before the month of application), eligibility for medical coverage begins with the month income is at or below the MANG(P) income standard. Income changes occurring after the month of authorization are not considered through the 60 day period following the last day of pregnancy.

(Source: Amended at 24 Ill. Reg. 7361, effective May 1, 2000)

Section 120.32 KidCare Parent Coverage Waiver Eligibility and Income Standard

a) A caretaker relative (see Section 120.390) who is 19 years of age or older qualifies for medical assistance when countable income is at or below the appropriate income standard and all MANG(C) eligibility requirements in this Part, with the exception of Sections 120.320 through 120.323, are met.

b) The appropriate income standard is 133 per cent of the Federal Poverty Income Guidelines, as published annually in the Federal Register, for the appropriate family size.

c) If income is greater than this amount, it is compared to the MANG(C) Income Standard in Section 120.30 to determine the spenddown amount.

(Source: Amended at 29 Ill. Reg. 820, effective January 1, 2005)

Section 120.40 Exceptions To Use Of MANG Income Standard

MANG (AABD)

a) An individual receiving long-term care in a licensed group care facility or a medical care facility is allowed $30 per month in lieu of the MANG standard.

b) Spouses sharing a room in a long term care facility, including a DMHDD facility or other medical care facility are considered residing together, if it is to their advantage when determining eligibility. For spouses considered residing together allow sixty dollars ($60) per month for each individual in lieu of the MANG standard.

c) A client 65 years of age and over receiving care in a State mental hospital is considered to be receiving long-term care.

d) Children under age 2l are considered to be receiving long-term care if they are residing in one of the following settings:

    l) Skilled nursing and intermediate care facilities approved for participation.

    2) Psychiatric hospitals approved for participation.

(Source: Amended at 13 Ill. Reg. 2081, effective February 3, 1989)

Section 120.50 AMI Income Standard (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

SUBPART C: FINANCIAL ELIGIBILITY DETERMINATION

Section 120.60 Cases Other Than Long Term Care, Pregnant Women and Certain Children

The following subsections apply to all cases other than those receiving care in licensed intermediate care facilities, licensed skilled nursing facilities, Department of Human Services (DHS) facilities, or DHS approved community based residential settings under 89 Ill. Adm. Code 140.643, or pregnant women and children under age 19 who do not qualify as mandatory categorically needy.

a) The eligibility period shall begin with:

1) the first day of the month of application;

2) the first day of any month, prior to the month of application, in which the client meets non-financial eligibility requirements up to three months prior to the month of application, if the client so desires; or

3) the first day of a month, after the month of application, in which the client meets non-financial eligibility requirements.

b) Eligibility Without Spenddown for MANG

1) For AABD MANG, if the client's nonexempt income available during the eligibility period is equal to or below the applicable MANG standard (Sections 120.20 and 120.30) and nonexempt assets are not in excess of the applicable asset disregard (Section 120.382), the client is eligible for medical assistance from the first day of the eligibility period. The Department will pay for covered services received during the entire eligibility period.

2) For TANF MANG, if the client’s nonexempt income available during the eligibility period is equal to or below the applicable MANG standard (Sections 120.20 and 120.30), the client is eligible for medical assistance from the first day of the eligibility period. The Department will pay for covered services received during the entire eligibility period.

3) The client is responsible for reporting any changes that occur during the eligibility period which might affect eligibility for medical assistance. If changes occur, appropriate action shall be taken by the Department, including termination of eligibility for medical assistance. If changes in income, assets or family composition occur which would make the client a spenddown case, a spenddown obligation will be determined and

subsection (c) of this Section will apply.

4) A redetermination of eligibility will be made at least every 12 months.

c) Eligibility with Spenddown for MANG

1) For AABD MANG, if the client's nonexempt income available during the applicable eligibility period is greater than the applicable MANG standard and/or nonexempt assets are over the applicable asset disregard, the client must meet the spenddown obligation determined for the eligibility period before becoming eligible to receive medical assistance. The spenddown obligation is the sum of the amount by which the client's nonexempt income exceeds the MANG standard and the amount of nonexempt assets in excess of the applicable asset disregard.

2) For TANF MANG, if the client's nonexempt income available during the applicable eligibility period is greater than the applicable MANG standard, the client must meet the spenddown obligation determined for the eligibility period before becoming eligible to receive medical assistance. The spenddown obligation is the amount by which the client's nonexempt income exceeds the MANG standard.

3) The client meets the spenddown obligation by incurring or paying for medical expenses in an amount equal to the spenddown obligation.

A) Medical expenses shall be applied to the spenddown obligation in the following order:

i) Expenses for necessary medical or remedial services, as funded by DHS from sources other than federal funds. Such expenses shall be based on the service provider's usual and customary charges to the public. Such expenses shall not be based on any nominal amount the provider may assess the client. These charges are considered incurred the first day of the month, regardless of the day the services are actually provided.

ii) Payments made for medical expenses within the previous six months. Payments are considered incurred the first day of the month of payment.

iii) Unpaid medical expenses. These are considered as of the date of service and are applied in chronological order.

B) If multiple medical expenses are incurred on the same day, the expenses shall be applied in the following order:

i) Health insurance deductibles (including Medicare and other co-insurance charges).

ii) All copayment charges incurred or paid on spenddown met day.

iii) Expenses for medical services and/or items not covered by the Department's Medical Assistance Program.

iv) Cost share amounts incurred for in-home care services by individuals receiving services through the Department on Aging (DonA).

v) Expenses incurred for in-home care services by individuals receiving or purchasing services from private providers.

vi) Expenses incurred for medical services or items covered by the Department's Medical Assistance Program. If more than one covered service is received on the day, the charges will be considered in order of amount. The bill for the smallest amount will be considered first.

C) If a service is provided during the eligibility period but payment may be made by a third party, such as an insurance company, the medical expense will not be considered towards spenddown until the bill is adjudicated. When adjudicated, that part determined to be the responsibility of the client shall be considered as incurred on the date of service.

4) After application for medical assistance for cases eligible with a spenddown obligation who do not have a QMB or MANG(P) member, an additional eligibility determination will be made.

A) For TANF MANG, if countable income is greater than the income standard (Section 120.30), and for AABD MANG, if countable income is greater than the income standard or countable assets are greater than the asset disregard (Section 120.382(d)), a person will not be enrolled in spenddown unless:

i) the person does not have a spenddown obligation for any month of the 12-month enrollment period;

ii) medical expenses equal the spenddown obligation for at least one month of the 12-month enrollment period; or

iii) the person is on a waiting list or would be on a waiting list to receive a transplant if he or she had a source of payment.

B) Cases which meet any of these conditions will be notified, in writing, of the spenddown obligation. The client will also be notified that his or her case will be reviewed beginning in the sixth month of the 12-month enrollment period. If the client has not had medical eligibility in one of the last three months at the time of review (including the month of review), the case will terminate unless the case contains a person who is on a waiting list or who would be on a waiting list to receive a transplant if he or she had a source of payment. A new application will be required if the client wishes continued medical assistance.

C) When proof of incurred medical expenses equal to the spenddown obligation is provided to the local office, eligibility for medical assistance shall begin effective the first day that the spenddown obligation is met. The Department will pay for covered services received from that date until the end of the eligibility period. The client shall be responsible, directly to the provider, for payment for services provided prior to the time the client meets the spenddown obligation.

5) Cases with a spenddown obligation which do not have a QMB, a MANG(P) member or a person on a waiting list or who would be on a waiting list to receive a transplant if he or she had a source of payment, will be reviewed beginning in the sixth month of enrollment to determine if they have had medical eligibility within the last three months, including the month of review. If so, enrollment will continue. If not, enrollment will be terminated and the client will be advised that if he or she wishes continued medical assistance, a reapplication must be filed. Upon reapplication, a new 12-month enrollment period will be established (assuming non-financial factors of eligibility are met). If appropriate, a new spenddown obligation will be created.

A) If the client files a reapplication prior to four months after the end of the period of enrollment, the client will be sent through a special

abbreviated intake procedure making use of current case record material to verify factors of eligibility not subject to change.

B) Cases that remain eligible in the tenth month of the enrollment period or which have a QMB, a MANG(P) member or a person on a waiting list or who would be on a waiting list to receive a transplant if he or she had a source of payment, will remain enrolled and will be redetermined once every 12 months.

6) The client is responsible for reporting any changes that occur during the enrollment period which might affect eligibility for medical assistance. If changes occur, appropriate action shall be taken by the Department, including termination of eligibility for medical assistance.

7) For AABD MANG, if changes in income, assets or family composition occur, appropriate adjustments to the spenddown obligation and date of eligibility for medical assistance shall be made by the Department. The client will be notified, in writing, of the new spenddown obligation.

A) If income decreases, or assets fall below the applicable asset disregard and, as a result, the client has already met the new spenddown obligation, eligibility for medical assistance shall be back-dated to the appropriate date.

B) If income or assets increase and, as a result, the client has not produced proof of incurred medical expenses equal to the new spenddown obligation, the written notification of the new spenddown amount will also inform the client that eligibility for medical assistance will be interrupted until proof of medical expenses equal to the new spenddown obligation is produced.

8) For TANF MANG, if changes in income or family composition occur, appropriate adjustments to the spenddown obligation and date of eligibility for medical assistance shall be made by the Department. The client will be notified, in writing, of the new spenddown obligation.

A) If income decreases and, as a result, the client has already met the new spenddown obligation, eligibility for medical assistance shall be back-dated to the appropriate date.

B) If income increases and, as a result, the client has not produced proof of incurred medical expenses equal to the new spenddown obligation, the written notification of the new spenddown amount

will also inform the client that eligibility for medical assistance will be interrupted until proof of medical expenses equal to the new spenddown obligation is produced.

(Source: Amended at 29 Ill. Reg. _____, effective September 30, 2005)

Section 120.61 Cases in Intermediate Care, Skilled Nursing Care and DMHDD - MANG (AABD) and All Other Licensed Medical Facilities

a) The policy set forth in subsections (b), (c), (d) and (e) below applies to cases receiving care in Licensed Intermediate Care Facilities, Licensed Skilled Nursing Facilities, or Department of Mental Health and Developmental Disabilities (DMHDD) Facilities. The policy set forth in subsection (f) below applies to cases receiving care in Licensed Intermediate Care Facilities, Licensed Skilled Nursing Facilities, DMHDD Facilities and all other Licensed Medical Facilities (see 89 Ill. Adm. Code 140.642).

b) Treatment of Resources

1) A one-month eligibility period will be used. All nonexempt income and non-exempt assets over the applicable asset disregard (Section 120.382) shall be applied towards the cost of care on a monthly basis. Non-exempt income (see Section 120.360) and assets (see 120.381) are applied towards the cost of care beginning with the first full calendar month of anticipated stay in the facility. Non-exempt income shall be applied toward the cost of care first. If insufficient to meet the cost of care at the private pay rate, then non-exempt assets over the applicable asset disregard shall be used.

2) When a client transfers between non-DMHDD facilities or transfers to a DMHDD facility, non-exempt income and/or excess assets are applied first toward the cost of care at the first facility and any balance is applied toward the cost of care at the second facility. If the client transfers from a DMHDD facility to a non-DMHDD facility, non-exempt income and/or excess assets are not applied toward the cost of care at the non-DMHDD facility for the month the transfer occurs. If the client is discharged from a DMHDD facility or non-DMHDD facility to his/her residence in the community or to a community based residential setting (such as Community Living Facility, Special Home Placement, Supported Living Arrangement, Home Individual Program, Community Residential Alternatives as defined at 59 Ill. Adm. Code 120.10), the MANG Community Income Standard is used (see Section 120.20) beginning with the month of discharge from the DMHDD facility or non-DMHDD.

3) If non-exempt income and non-exempt assets over the applicable asset disregard are greater than the Department's rate for cost of care, no payment will be made to the facility. However, the client may become eligible for Medical Assistance for other medical expenses by incurring medical expenses equal to the spend-down obligation. The private rate of the facility may be applied to the spend-down obligation in this instance. A full redetermination shall be made every twelve (12) months.

c) Allow a deduction from the MANG client's income to meet the needs of dependent children under age 2l who do not reside with the community spouse, who do not have enough income to meet their needs and whose assets do not exceed the asset limit.

To determine needs and asset limits:

1) for dependent children, use AFDC MAG standard and asset disregard (see Sections 120.30 and 120.382).
2) allow any payments made on medical bills for the children.

d) Allow deductions from the MANG clients non-SSI income for a Community Spouse Maintenance Needs Allowance and a Family Maintenance Needs Allowance for each dependent family member who does not have enough income to meet his/her needs. Family members include dependent children under age 21, dependent adult children, dependent parents or dependent siblings of either spouse who are living with the community spouse. To determine the amount of the deduction:

1) The deduction for the Community Spouse Maintenance Needs Allowance, as of October 1, 1989, is equal to the community spouse maintenance needs standard ($1,500) less any non-exempt monthly income of the community spouse. The amount established as the community spouse maintenance needs standard shall be increased for calendar years after 1989 by the same percentage as the percentage increase in the consumer price index for all urban consumers. The deduction is allowed only to the extent income of the institutionalized spouse is contributed to the community spouse. However, the deduction for the Community Spouse Maintenance Needs Allowance shall not be less than the amount ordered by the court for support of the community spouse or the amount determined as the result of the fair hearing.
2) The deduction for the Family Maintenance Needs Allowance for each dependent family member is equal to one-third of the difference between the family maintenance needs standard (122% of the Federal Poverty Level for two persons as of September 30, 1989, 133% as of July 1, 1991 and 150% as of July 1, 1992) and any non-exempt income of the family member.

e) Allow a $90.00 per month income disregard for veterans who have neither spouse nor dependent child, or surviving spouses, who do not have a dependent child, who reside in long term care facilities and who receive reduced monthly veterans benefits in the amount of $90.00. Persons allowed the $90.00 per month income disregard are not also permitted the $30.00 per month personal allowance (see Section 120.40).

f) Deduction from MANG program

1) A deduction from the MANG program participant's income shall be permitted for up to six months to maintain a residence in the community when:
   A) the individual does not have a spouse and/or dependent children in the home; and
   B) a physician has certified that the stay in the facility is temporary and the individual is expected to return home within six months.
2) To determine the amount of the deduction include:
   A) rent or property expense that would be allowed in the AABD MAG standard if the individual was at home; and
   B) utility expenses that would be allowed in the AABD MAG standard if

the individual was at home.

(Source: Amended at 17 Ill. Reg. 10402, effective June 28, 1993)

Section 120.62 Department of Mental Health and Developmental Disabilities (DMHDD) Approved Home and Community Based Residential Settings Under 89 Ill. Adm. Code 140.643

a) Community-based Residential Settings
   1) The following rule applies to individuals receiving in-home care services through the Department of Mental Health and Developmental Disabilities (DMHDD) in accord with 89 Ill. Adm. Code 140.643. The in-home care services are provided in the following community based residential settings.
      A) Community Living Facilities (CLF)
      B) Special Home Placements (SHP)
      C) Supported Living Arrangement (SLA)
      D) Home Individual Program (HIP)
      E) Community Residential Alternatives (CRA)
   2) A definition of the above quoted Home and Community based residential settings as well as a description of the Title XIX waiver services can be found at 59 Ill. Adm. Code 120.

b) A one-month eligibility period will be used. Eligibility begins the first day of the eligibility period or the day during the month that spend-down is met.

c) A one-person MANG Community Income Standard will be used (see Section 120.20).

d) The client shall be allowed an asset disregard in the amount for one client in accord with Section 120.382. Assets are considered in accord with 89 Ill. Adm. Code 113.140, 113.141, 113.142 and 113.154.

e) If the client has SSI income, the SSI income will be applied by DMHDD toward the cost of room and board. However, no payment will be made by the Department for the cost of room and board. The client shall be responsible directly to DMHDD for payment of room and board costs.

f) If the client's non-exempt income is greater than the MANG standard and/or non-exempt assets are over the applicable asset disregard, the client must meet the spend-down obligation determined for the eligibility period before becoming eligible to receive Medical Assistance. The spend-down obligation is the sum of the amount by which the client's non-exempt income exceeds the MANG standard and the amount of non-exempt assets in excess of the applicable asset disregard.

g) The client may meet the spend-down by incurring Title XIX waiver (in-home care) services. Waiver services are considered incurred in total for the month on the first day of the month or the first day of stay for a month that the client resides in the approved residential setting if for less than an entire month. If the cost of waiver services equals or exceeds the spend-down amount, the spend-down obligation is met. DMHDD will provide the local office a statement of expected monthly charges for waiver services to ensure that the spend-down obligation is met.

h) If the client's non-exempt income is equal to or less than the MANG Standard and non-exempt assets are not in excess of the applicable asset disregard, the client is

eligible for medical assistance from the first day of the eligibility period.

i) If the client's non-exempt income exceeds the MANG Standard and/or non-exempt assets are over the applicable asset disregard, eligibility for medical assistance shall begin effective the first day that the spend-down obligation is met. The Department will pay for covered services less the client's liability (excluding Title XIX waiver services) received from the date the spend-down obligation is met date until the end of the eligibility period. The client shall be responsible directly to the provider for payment for services provided prior to the time client meets the spend-down obligation.

j) A new application and/or a redetermination of eligibility will not be required for eligible clients who move from an institutional setting to an approved Home and Community based residential setting.

k) A case review is required for eligible cases placed in an approved residential setting.

l) A full redetermination of eligibility shall be made every twelve months.

(Source: Amended at 14 Ill. Reg. 4233, effective March 5, 1990)

Section 120.63 Department of Mental Health and Developmental Disabilities (DMHDD) Approved Home and Community Based Residential Settings

a) In-Home Care Services
   1) This Section applies to individuals receiving remedial care services through the Department of Mental Health and Developmental Disabilities (DMHDD) in Home and Community Based Residential Settings approved by DMHDD. Remedial care services are those services (except for room and board) provided by DMHDD that are directed toward meeting the needs of disabled clients who are not receiving services through the Department's In-Home Care Program (see Section 120.62). The remedial care services are provided in the following Home and Community Based Residential Settings:
      A) Community Living Facilities (CLF)
      B) Special Home Placements (SHP)
      C) Supported Living Arrangement (SLA)
      D) Home Individual Program (HIP)
      E) Community Residential Alternatives (CRA)
   2) A definition of the Home and Community Based Residential Settings can be found at 59 Ill. Adm. Code 120.

b) A one-month eligibility period will be used. Eligibility begins the first day of the eligibility period or the day during the month that spend-down is met.

c) A one-person MANG Community Income Standard will be used (see Section 120.20).

d) The client shall be allowed an asset disregard in the amount for one client in accord with Section 120.382. Assets are considered in accord with 89 Ill. Adm. Code 113.140, 113.141, 113.142 and 113.154.

e) If the client has SSI income, the SSI income will be applied by DMHDD toward the cost of room and board. The client shall be responsible directly to DMHDD for payment of room and board costs. No payment will be made by the Department for the cost of room and board.

f) If the client's non-exempt income is greater than the MANG Standard and/or non-exempt assets are over the applicable asset disregard, the client must meet the spend-down obligation determined for the eligibility period before becoming eligible to receive medical assistance. The spend-down obligation is the sum of the amount by which the client's non-exempt income exceeds the MANG Standard and the amount of non-exempt assets in excess of the applicable asset disregard.

g) The client may meet the spend-down by incurring costs for remedial care services. Remedial care costs are the cost of all services reported by DMHDD that exceed the MANG Community Income Standard and the Income Disregard amount. Remedial care services are considered incurred in total for the month on the first day of the month or the first day of stay for a month that the client resides in the approved residential setting if for less than an entire month. If the cost of remedial care services equal or exceeds the spend-down amount, the spend-down obligation is met.

DMHDD will provide the local office a statement of expected monthly charges for remedial care services to ensure that the spend-down obligation is met.

h) If the client's non-exempt income is equal to or less than the MANG Standard and non-exempt assets are not in excess of the applicable asset disregard, the client is eligible for medical assistance from the first day of the eligibility period.

i) If the client's non-exempt income exceeds the MANG Standard and/or non-exempt assets are over the applicable asset disregard, eligibility for medical assistance shall begin effective the first day that the spend-down obligation is met. Covered services, less the client's liability, received from the spend-down met date until the end of the eligibility period will be paid for by the Department. The client shall be responsible directly to the provider for payment for services provided prior to the time client meets the spend-down obligation.

j) A new application and/or a redetermination of eligibility will not be required for eligible clients who move from an institutional setting to an approved Home and Community Based Residential Setting.

k) A case review is required for eligible cases placed in an approved Home and Community Based Residential Setting.

l) A full redetermination of eligibility shall be made every twelve months.

(Source: Amended at 14 Ill. Reg. 4233, effective March 5, 1990)

Section 120.64 MANG(P) Cases

a) The following subsections apply to MANG(P) clients. The eligibility period for a MANG(P) client shall begin with:
   1) the first day of the month of application; or
   2) the first day of any month prior to the month of application if the client so desires up to three months prior to the month of application; or
   3) the first day of the month after the month of application; or
   4) the first day of a month a pregnant woman and/or child under age 19 meets the requirements of Sections 120.11 and 120.31.

b) The pregnant woman shall be eligible to receive medical assistance until 60 days following the last day of pregnancy. The 60 day medical coverage continues through the last day of the calendar month in which the 60 day period ends. The 60 day medical coverage period shall be provided for all women determined eligible for medical assistance under Section 120.11(a)(1) of this Section including women who are no longer pregnant at the time of application because the woman gave birth or had a miscarriage or an abortion, and including women who signed an adoption agreement.

c) Children shall be eligible to receive medical assistance as determined pursuant to Section 120.400.

d) Covered services received during the entire eligibility period will be paid by the Department (see 89 Ill. Adm. Code 140.3).

e) A redetermination of eligibility for MANG(P) will be made every 12 months for children under age 19.

f) The client is responsible to report any changes that occur during the eligibility period which might affect eligibility for MANG(P). If changes in income or family composition occur which would make the client ineligible for MANG(P), appropriate action shall be taken by the Department, including evaluation of eligibility for other programs or termination of eligibility for medical assistance. Income changes occurring after a pregnant woman is determined eligible for MANG(P) coverage are not considered through the 60 day postpartum period following the last day of pregnancy.

g) MANG(P) clients shall be eligible without a spenddown obligation amount.

h) A review of case eligibility for MANG(C) will be conducted for a pregnant woman during the second month of the 60 day extended medical coverage period. If eligible, the case shall be transferred by the Department to the appropriate program without interruption in benefit eligibility. If ineligible, the Department shall notify the client in writing.

i) A review of case eligibility for TANF MANG(C) will be conducted when a child is determined ineligible for MANG (P). If the child is eligible for TANF MANG(C), the case shall be transferred by the Department without interruption in benefit eligibility. If ineligible, written notification shall be provided to the client.

(Source: Amended at 24 Ill. Reg. 7361, effective May 1, 2000)

Section 120.65 Department of Mental Health and Developmental Disabilities (DMHDD) Licensed Community - Integrated Living Arrangements

a) Community-Integrated Living Arrangement (CILA) Services
   1) This Section applies to individuals receiving CILA services through an agency licensed by DMHDD. CILA services are provided in approved settings where eight or fewer individuals with mental retardation (MR) or mental illness (MI) reside under the supervision of the agency licensed by DMHDD. Individuals actively participate in choosing services designed to provide treatment, habilitation, training, rehabilitation and other community integrative supports and in choosing a home from among those living arrangements available to the general public and/or housing owned or leased by an agency licensed by DMHDD.
   2) The standards and licensure requirements for community-integrated living arrangements are found at 59 Ill. Adm. Code 115.

b) A one-month eligibility period will be used. Eligibility begins the first day of the eligibility period or the day during the month that spend-down is met.

c) The appropriate MANG Community Income Standard will be used (see Section 120.20).

d) The individual shall be allowed an asset disregard in accordance with Section 120.382. Assets are considered in accordance with 89 Ill. Adm. Code 113.140, 113.141 and 113.142.

e) No payment will be made by the Department for the cost of room and board. The individual shall be responsible directly to the agency licensed by DMHDD for payment of any room and board costs.

f) If non-exempt income is greater than the MANG Standard and/or non-exempt assets are over the applicable asset disregard, the client must meet the spend-down determined for the eligibility period before becoming eligible to receive medical assistance. The spend-down is the sum of the amount by which the client's non-exempt income exceeds the MANG standard and the amount of non-exempt assets in excess of the applicable asset disregard.

g) The client may meet the spend-down by incurring costs for CILA services. CILA services are considered incurred in total for the month on the first day of the month or the first day services are received if for less than an entire month. If the cost of CILA services equals or exceeds the spend-down amount, the spend-down is met. DMHDD will provide the local office with a statement of expected monthly charges for CILA services to ensure that the spend-down obligation is met.

h) If non-exempt income is equal to or less than the MANG Standard and non-exempt assets are not in excess of the applicable asset disregard, the client is eligible for medical assistance from the first day of the eligibility period.

i) If non-exempt income exceeds the MANG Standard and/or non-exempt assets are over the applicable asset disregard, eligibility for medical assistance shall begin effective the first day that the spend-down obligation is met. Covered services, less

the client's liability, received from the spend-down met date until the end of the eligibility period will be paid for by the Department. The client shall be responsible directly to the provider for payment for services provided prior to the time the client meets spend-down.

j) A new application and/or a redetermination of eligibilty will not be required for eligible clients who move from an institutional setting to an approved setting in which CILA services are received.

k) A full redetermination of eligibility shall be made every twelve months.

(Source: Added at 15 Ill. Reg. 11973, effective June 24, 1991)

SUBPART D: MEDICARE PREMIUMS

Section 120.70 Supplementary Medical Insurance Benefits (SMIB) Buy-In Program

a) The Department shall pay the premium for Supplementary Medical Insurance benefits (SMIB) (Part B of Medicare) for specified clients in accordance with the buy-in agreement with the Social Security Administration (SSA) and the Medicare Catastrophic Coverage Act of l988 (P.L. 100-360). Individuals may previously have enrolled in SMIB themselves or they will be enrolled by the Department.

b) Eligible Individuals

1) The Department shall pay the SMIB premium for the following individuals:

A) individuals who receive financial assistance (including zero grant) under the AABD or AFDC program;

B) individuals who, except for the Social Security benefit increase of l972 (42 CFR 435.134), would still be eligible to receive cash assistance as an aged, blind or disabled person (89 Ill. Adm. Code 113) and who are eligible for both SMIB and the Department's Medicaid program (89 Ill. Adm. Code 120);

C) individuals with Supplemental Security Income (SSI) income who receive full Medicaid benefits under the AABD program; and

D) Qualified Medicare Beneficiaries (QMB)s (see Section l20.72).

E) Specified Low-Income Medicare Beneficiaries (SLIB)s (see Section 120.73).

2) Individuals who qualify under subsections (b)(l)(A) thru (b)(1)(C) above may include individuals not eligible for Part A of Medicare (see Title XVIII of the Social Security Act).

c) Beginning Eligibility

1) Individuals who qualify under subsections (b)(l)(A), (b)(1)(B) or (b)(1)(C) shall be added to the SMIB Buy-in Program for the first month in which they are eligible for both SMIB enrollment and medical assistance. Recipients shall remain in the Buy-in Program while in $0 grant status and for any month in which they qualify under (b)(l)(A) thru (b)(1)(D) above.

2) Individuals who qualify under subsection (b)(1)(D) shall be added to the SMIB Buy-in Program for the first month following the month in which they are determined eligible for QMB status. Recipients shall remain in the SMIB Buy-in Program for any month in which they qualify under subsection (b)(l)(A) thru (b)(1)(D) above.

3) Individuals who qualify under subsection (b)(1)(E) may be added to the SMIB Buy-in Program effective three months prior to the month of application for SLIB benefits only or SLIB benefits and medical assistance.

(Source: Amended at 17 Ill. Reg. 6827, effective April 21, 1993)

Section 120.72 Eligibility for Medicare Cost Sharing as a Qualified Medicare Beneficiary (QMB)

a) Eligibility for Medicare cost sharing exists for Qualified Medicare Beneficiaries (QMB)s. A QMB is an individual who:
   l) is a beneficiary of Medicare Part A (i.e. Hospital Insurance);
   2) meets the general non-financial factors of eligibility for the Medicaid Program (see Sections l20.3l0, l20.3ll, l20.3l9 and l20.325);
   3) has countable monthly income which does not exceed the QMB income standard (see Section l20.74); and
   4) has countable assets which do not exceed the QMB asset disregard (see Section l20.382(d)).

b) When considering Social Security Benefits, the monthly amount to consider for January through the month following the month in which the annual Federal Poverty Level amounts are announced will not include the annual Retirement Survivors Disability Insurance (RSDI) Cost of Living Adjustment (COLA). For all other months of the year the full amount of RSDI benefits will be considered.

c) QMBs may be eligible for the full range of Medicaid services (see 89 Ill. Adm. Code 140) only if they meet all eligibility requirements for Medicaid (see 89 Ill. Adm. Code 120).

d) Eligibility for Medicare cost sharing is effective the first day of the month following the QMB eligibility determination.

e) QMBs are eligible for Medicaid payment of Medicare cost sharing expenses (i.e., Part A and Part B premiums, deductibles and coinsurance (See Title XVIII of the Social Security Act.)) in accordance with Sections l20.70, l20.76 and 89 Ill. Adm. Code l40.2l.

f) Eligibility for QMB status will be redetermined at least every twelve (l2) months.

(Source: Amended at 15 Ill. Reg. 5302, effective April 1, 1991)

Section 120.73 Eligibility for Medicaid Payment of Medicare Part B Premiums as a Specified Low-Income Medicare Beneficiary (SLIB)

a) Eligibility for Medicaid payment of Medicare Part B premiums exists for Specified Low-Income Medicare Beneficiaries (SLIB)s. A SLIB is an individual who:
   l) is a beneficiary of Medicare Part A (i.e. Hospital Insurance);
   2) meets the general non-financial factors of eligibility for the Medicaid Program (see Sections 120.310, 120.311, 120.319 and 120.325);
   3) has countable monthly income which exceeds the Qualified Medicare Beneficiary (QMB) income standard (see Section 120.74), but is less than or equal to the SLIB income standard (see Section 120.75); and
   4) has countable assets which do not exceed the QMB asset disregard (see Section 120.382(d)).

b) When considering Social Security Benefits, the monthly amount to consider for January through the month following the month in which the annual Federal Poverty Level (FPL) amounts are announced will not include the annual Retirement Survivors Disability Insurance (RSDI) Cost of Living Adjustment (COLA). For all other months of the year the full amount of RSDI benefits will be considered.

c) SLIBs with incomes from 100 percent of the FPL up to 120 percent of the FPL may be eligible for the full range of Medicaid services (see 89 Ill. Adm. Code 140) only if they meet all eligibility requirements for Medicaid (see 89 Ill. Adm. Code 120).

d) Individuals with incomes of at least 120 percent of the FPL but less than 175 percent of the FPL, who receive Medicaid benefits, are not eligible for the benefits described in subsection (g) of this Section.

e) Eligibility for Medicaid Payment of Medicare Part B premiums may be effective up to three months prior to the month of application.

f) Eligibility for SLIB status will be redetermined at least every 12 months.

g) SLIBs with incomes from 100 percent of the FPL up to 135 percent of the FPL are eligible for Medicaid payment of Medicare Part B premiums (see Title XVIII of the Social Security Act), in accordance with Sections 120.70 and 89 Ill. Adm. Code 140.21. Individuals with incomes from 135 percent of the FPL up to 175 percent of the FPL are not eligible for Medicaid payment of Part B Medicare premiums. These persons are only eligible for a monthly payment that is for the portion of Medicare cost sharing described in the Social Security Act (U.S.C. 1905(p)(3)(A)(ii)).

(Source: Amended at 22 Ill. Reg. 8503, effective May 1, 1998)

Section 120.74 Qualified Medicare Beneficiary (QMB) Income Standard

The QMB income standard is equal to a percentage of the then current Federal Poverty Level Income Guidelines as published annually in the Federal Register) for the size of the household. If the household's countable monthly income (see 89 Ill. Adm. Code 112, 113, 120) exceeds the QMB income standard, eligibility for QMB status does not exist. The timetable for the applicable percentage is as follows:

January - December 1989	80%
January - December 1990	85%
January - December 1991	95%
January - December 1992	100%

(Source: Amended at 15 Ill. Reg. 5302, effective April 1, 1991)

Section 120.75 Specified Low-Income Medicare Beneficiary (SLIB) Income Standards

The SLIB income standards are equal to a percentage of the then current Federal Poverty Level (FPL) Income Guidelines as published annually in the Federal Register for the size of the household. If the household's countable monthly income (see 89 Ill. Adm. Code 112, 113, 120) exceeds the appropriate SLIB income standard, eligibility for SLIB status does not exist. The applicable percentages are as follows:

a) Effective January 5, 1998, the SLIB income standard is at least 100 percent of the FPL, but less than 135 percent of the FPL.

b) Effective January 5, 1998, persons with incomes that are at least 135 percent of the FPL but less than 175 percent of the FPL, may receive the special monthly payment described in Section 120.73(g).

(Source: Amended at 22 Ill. Reg. 8503, effective May 1, 1998)

Section 120.76 Hospital Insurance Benefits (HIB)

a) The Department shall pay the Hospital Insurance Benefit (HIB) (Part A of Medicare) premium for Qualified Medicare Beneficiaries (QMBs) (see Section l20.72). Payments will be made in behalf of QMBs who have individually enrolled for HIB with the Social Security Administration and who are charged a HIB premium.

b) The Department will pay the HIB premium beginning the month following the month of the QMB eligibility determination. Payment will continue as long as the individual retains QMB status.

(Source: Amended at 14 Ill. Reg. 7637, effective May 10, 1990)

SUBPART E: RECIPIENT RESTRICTION PROGRAM

Section 120.80 Recipient Restriction Program

a) The Recipient Restriction Program (RRP) shall identify recipients who unnecessarily utilize medical services. When the Department determines, on the basis of statistical norms and the medical judgment of physicians and/or pharmacologists, that a Medicaid recipient has received medical services that are not medically necessary based on the recipient's diagnoses and/or medical condition or conditions or in such a manner as to constitute an abuse of medical privileges, the decision to restrict a recipient to a Primary Care Provider and/or Primary Care Pharmacy will be made. RRP applies to all medical assistance programs administered by the Department.

b) Primary and Secondary Sources of Recipient Identification

1) The primary source of recipient identification shall be the Surveillance and Utilization Review Subsystem (SURS) of the Medicaid Management Information System (MMIS). On a quarterly basis, SURS analyzes the entire Medicaid population, determines medical usage per recipient and will identify recipients with usages in excess of the quarterly established norm of recipients in the same category of assistance and like demographic areas.

2) Secondary sources of identification shall be incoming referrals, such as referrals from medical providers, law enforcement officials or members of the general public. All referrals shall be reviewed and analyzed. Recipients found to have loaned or altered their medical cards for the purpose of obtaining medical benefits for which they or other persons are not legitimately entitled; falsely represented medical coverage; found in possession of blank or forged prescription pads; or who knowingly assisted providers in rendering excessive services or defrauding the Medical Assistance Program shall be restricted.

c) Once a recipient is identified, medical usage based on diagnoses and/or medical condition for the nine months preceding identification shall be reviewed. Medical Assistance Consultants, licensed physicians and/or pharmacologists will determine if the recipient should be restricted due to the medical services received being not medically necessary. The Department shall initially designate, without regard to choice, a Primary Care Provider and/or Primary Care Pharmacy. The Department's designation shall remain in effect for the entire period of the restriction unless the recipient changes this designation pursuant to subsection (f) of this Section. Each recipient to be restricted will be notified in writing. This notice will also contain a statement relating to the medical necessity of services consistent with the findings of

the professional consultants; a statement advising the recipient of his or her right to appeal; and a toll-free number to call for information.

d) Department Designated Primary Care Provider and/or Primary Care Pharmacy

1) The Department will select one provider and/or one pharmacy in reasonable geographical proximity to the recipient's home to serve as the recipient's Primary Care Provider and/or Primary Care Pharmacy.

2) The primary care physician shall be a medical doctor or doctor of osteopathy, licensed to practice medicine in all its branches, or a clinic enrolled to provide primary care; a properly registered Medicaid provider in good standing with the Department per the physician registration; enrolled to provide physician services with the Department; and willing to serve as the primary care provider.

e) Types of Services Provided or Authorized

1) Once restricted, the Recipient Eligibility Verification (REV) system shall display information regarding the Primary Care Provider and/or Primary Care Pharmacy. REV will also display information that emergency services will not be restricted. If restricted to a Primary Care Provider, the Primary Care Provider must provide or authorize the following non-emergency ambulatory care services for the restricted recipient before the Department will render payment for the services:

A) Clinic

B) Laboratory

C) Outpatient Hospital

D) Pharmacy

E) Physician

2) The Primary Care Pharmacy must supply all prescriptions. Authorization to obtain non-emergency prescriptions from any other source will only be approved in such instances when a specific item is not part of the Primary Care Pharmacy's inventory and cannot be acquired through the Primary Care Pharmacy.

3) Other covered services may be provided by a qualified provider in the Department's Medical Program.

f) Changing the Designated Primary Care Provider and/or Primary Care Pharmacy

1) The recipient may change the Department's initial designation of a Primary Care Provider or Primary Care Pharmacy once without cause. The request for change must be submitted to the Department in writing. The Department, by notice, shall inform the recipient how to request a change in Primary Care Provider or Primary Care Pharmacy.

2) The recipient may change his or her designated provider for cause if one of the following circumstances is verified:

A) Change of recipient's residence from the geographic area of the Primary Care Provider or Primary Care Pharmacy;

B) Change in the recipient's medical condition which the Primary Care Provider is unable to treat or refer to another provider;

C) Death of the Primary Care Provider;

D) Disenrollment of the Primary Care Provider and/or Primary Care Pharmacy from the Medical Assistance Program; and

E) Notice from the Primary Care Provider and/or Primary Care Pharmacy that they will no longer serve as the Primary Care Provider.

3) The Department will notify the recipient in writing if the Primary Care Provider and/or Primary Care Pharmacy has disenrolled as a provider of Medicaid services or if the provider notifies the Department of their unwillingness to continue to serve as the recipient's Primary Care Provider.

4) Changes in designated Primary Care Provider and/or Primary Care Pharmacy shall be processed effective with the earliest possible date reflected on the eligibility file.

5) For the provider or pharmacy, the Department will determine if the requested change meets the criteria in subsection (d) of this Section.

g) Length of Restriction

1) Once recipients are restricted they remain in restriction for a minimum of four full quarters. If restricted recipients transfer to a different assistance unit, the restriction will be processed to follow the recipient. If a restricted recipient becomes inactive and is subsequently reactivated, the restriction will be reactivated until such time as four full quarters have elapsed.

2) Reevaluation of the Recipient's Medical Usage

A) When a recipient has had his or her medical card restricted for four full quarters, the Department shall reevaluate the recipient's medical usage to determine whether the recipient continues to receive medical services that are not medically necessary. The Department shall evaluate each case not later than eighteen months after the effective date of restriction. If the recipient is still receiving medical services that are not medically necessary, the restriction shall be continued for an additional period of eight full quarters. This additional period of eight full quarters shall begin with the first month immediately following the end of the first four full quarter restriction period. If the recipient no longer is receiving medical services that are not medically necessary, the restriction shall be discontinued. A "quarter", for purposes of this Section, shall be defined as one of the following three-month periods of time: January-March, April-June, July-September or October-December.

B) If necessary to determine if medical services that are not medically necessary are still being received, the Department shall obtain a complete copy of the recipient's medical record from the Primary Care Provider. The medical record will be reviewed by the Medical Assistant Consultant with a final determination by a licensed physician and/or pharmacologist to determine if the medical services received were medically necessary.

C) If the decision is to release the recipient from restriction, such release will be processed effective with the earliest possible date reflected on the eligibility file.

D) If the services are determined to be medically unnecessary, the recipient will be notified in writing of the continued restriction. The Department may designate a different Primary Care Physician and/or Primary Care Pharmacy. The criteria in subsection (d) of this Section shall apply. This notice will also contain a statement relating to the medical necessity of services consistent with the findings of the

professional consultants; a statement advising the recipient of his or her right to appeal; and a toll-free number to call for information.

3) If the restriction is continued, a review will be conducted in accordance with subsection (g)(2) of this Section, subsequent to the additional eight quarter period.

4) A recipient who has been restricted under this Section, is released and then is restricted under this Section a subsequent time, shall be restricted for a period of eight full quarters. Subsequent to this eight quarter period, a review will be conducted in accordance with subsection (g)(2) of this Section.

h) Recipients have the right to appeal inclusion in the program. (See 89 Ill. Adm. Code 102.80 through 102.84.)

i) Any recipient in the RRP is not permitted to enroll in a Managed Care Organization (MCO).

j) Any recipient designated by the Department for restriction in the RRP who is, at that time, enrolled in an MCO will be disenrolled from the MCO upon the RRP designation.

(Source: Amended at 28 Ill. Reg. 14541, effective November 1, 2004)

SUBPART F: MIGRANT MEDICAL PROGRAM

Section 120.90 Migrant Medical Program (Repealed)

(Source: Repealed at 24 Ill. Reg. 18309, effective December 1, 2000)

Section 120.91 Income Standards (Repealed)

(Source: Repealed at 24 Ill. Reg. 18309, effective December 1, 2000)

SUBPART G: AID TO THE MEDICALLY INDIGENT

Section 120.200 Elimination Of Aid To The Medically Indigent

Effective August 1, 1991, the Aid to the Medically Indigent Program (AMI) was eliminated pursuant to Public Act 87-14. Any references to the AMI program contained in the Department's rules are obsolete and of no effect as of August 1, 1991.

(Source: Added at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.208 Client Cooperation (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.210 Citizenship (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.211 Residence (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.212 Age (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.215 Relationship (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.216 Living Arrangement (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.217 Supplemental Payments (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.218 Institutional Status (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.224 Foster Care Program (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.225 Social Security Numbers (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.230 Unearned Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.235 Exempt Unearned Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.236 Education Benefits (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.240 Unearned Income In-Kind (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.245 Earmarked Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.250 Lump Sum Payments and Income Tax Refunds (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.255 Protected Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.260 Earned Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.261 Budgeting Earned Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.262 Exempt Earned Income (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.270 Recognized Employment Expenses (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.271 Income From Work/Study/Training Program (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.272 Earned Income From Self-Employment (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.273 Earned Income From Roomer and Boarder (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.275 Earned Income In-Kind (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.276 Payments from the Illinois Department of Children and Family Services (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.280 Assets (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.281 Exempt Assets (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.282 Asset Disregards (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.283 Deferral of Consideration of Assets (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.284 Spend-down of Assets (AMI) (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.285 Property Transfers (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.290 Persons Who May Be Included in the Assistance Unit (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

Section 120.295 Payment Levels for AMI (Repealed)

(Source: Repealed at 16 Ill. Reg. 139, effective December 24, 1991)

SUBPART H: MEDICAL ASSISTANCE -- NO GRANT

Section 120.308 Client Cooperation

a) As a condition of eligibility, clients must cooperate:
   1) in the determination of eligibility;
   2) with Department programs conducted for the purposes of acquisition or verification of information upon which eligibility may depend;
   3) in applying for all financial benefits for which they may qualify and to avail themselves of such benefits at the earliest possible date.

b) Clients are required to avail themselves of all potential resources.

c) When eligibility cannot be conclusively determined because the individual is unwilling or fails to provide essential information or to consent to verification, the client is ineligible.

d) At screening, applicants shall be informed, in writing, of any information they are to provide at the eligibility interview.

e) At the eligibility interview or at any time during the application process, when the applicant is requested to provide information in his or her possession, the Department will allow ten (10) days for the return of the requested information. The first day of the ten (10) day period is the calendar day following the date the information request form is sent or given to the applicant. The last day of the ten (10) day period shall be a work day and is to be indicated on the information request form. If the applicant does not provide the information by the date on the information request form, the application shall be denied on the following work day.

f) At the eligibility interview or at any time during the application process, when the applicant is requested to provide third party information, the Department shall allow ten (10) days for the return of the requested information or for verification that the third party information has been requested. The first day of the ten (10) day period is the calendar day following the date the information request form is sent or given to the applicant. The last day of the ten (10) day period shall be a work day and is to be indicated on the information request form. It is to be indicated on the information request form that the applicant shall provide written verification of the request for the third party information. If the applicant does not provide the information or the verification that the information was requested by the date on the information request form, the application shall be denied on the following work day.
   1) Third party information is defined as information which must be provided by someone other than the applicant. An authorized representative or person applying on another's behalf is not a third party but is treated as if he were the applicant.
   2) The Department shall advise clients of the need to provide written verification of third party information requests and the consequences of failing to provide such verification.
   3) If the applicant requests an extension either verbally or in writing in order to

obtain third party information and provides written verification of the request for the third party information such as a copy of the request that was sent to the third party, an extension of forty-five (45) days from the date of application shall be granted. The first day of the forty-five (45) day period is the calendar day following the date of application. The 45th day must be a work day.

4) If an applicant's attempt to obtain third party information is unsuccessful, upon the applicant's request the Department will assist in securing evidence to support the client's eligibility for assistance.

(Source: Amended at 14 Ill. Reg. 13227, effective August 6, 1990)

Section 120.309 Caretaker Relative

a) The caretaker relative is the specified relative with whom the child is living. When a dependent child lives with a parent that parent shall be designated as the caretaker relative.

b) Every MANG(C) case shall have one person designated as the caretaker relative. The caretaker relative does not have to meet a minimum or a maximum age requirement and if the caretaker relative is included in the assistance unit, this person shall no longer be considered a dependent child. No person shall serve as caretaker relative for more than one AFDC grant case at the same time, except for an AFDC-U parent whose child's eligibility is based on the lack of parental support or care of that child's other parent.

c) An exception to the above shall occur when no specified relative is immediately available to act as a caretaker relative. (In this situation, another person may serve as a Temporary Caretaker for a period not to exceed 90 days.) "Living with" requirements of the child(ren) are the same as with a caretaker relative. The Temporary Caretaker will not be included in the assistance unit.

(Source: Added (by codification with no substantive change) at 7 Ill. Reg. 16108)

Section 120.310 Citizenship

To be eligible for assistance, an individual shall be either a United States (U.S.) citizen or a non-citizen within specific categories and subject to specific restrictions ~~as~~ set forth below:

a) Citizenship status -- Persons born in the U.S., or in its possessions, are U.S. citizens. Citizenship can also be acquired by naturalization through court proceedings, or by certain persons born in a foreign country of U.S. citizen parents.

b) Non-citizens

1) The following categories of non-citizens may receive assistance, if otherwise eligible:

A) A U.S. veteran honorably discharged and a person on active military duty, and the spouse and unmarried dependent children of such a person;

B) Refugees under Section 207 of the Immigration and Nationality Act (INA);

C) Asylees under Section 208 of the INA;

D) Persons for whom deportation has been withheld under Section 243(h) of the INA;

E) Persons granted conditional entry under Section 203(a)(7) of the INA as in effect prior to April 1, 1980;

F) Persons lawfully admitted for permanent residence under the INA;

G) Parolees, for at least one year, under Section 212(d)(5) of the INA;

H) Nationals of Cuba or Haiti;

I) Persons identified by the Federal Office of Refugee Resettlement (ORR) as victims of trafficking;

J) Amerasians from Vietnam;

K) Members of the Hmong or Highland Laotian tribe when the tribe helped U.S. personnel by taking part in a military or rescue operation

during the Vietnam era;

L) American Indians born in Canada; and

M) Persons who are a spouse, widow or child of a U. S. citizen or a spouse or child of a legal permanent resident (LPR) who have been battered or subjected to extreme cruelty by the U. S. citizen or LPR or a member of that relative's family who lived with them, who no longer live with the abuser or plan to live separately within one month of assistance and whose need for assistance is due, at least in part, to the abuse.

2) Those persons who are in the categories set forth in subsections (b)(1)(F) and (b)(1)(G) of this Section, who enter the United States on or after August 22, 1996, shall not be eligible for five years beginning on the date the person entered the United States.

3) Notwithstanding the provisions of subsections (b)(1) and (2) of this Section, any non-citizen is eligible for medical assistance if the non-citizen otherwise meets the income, asset and categorical requirements of the medical assistance program and is in need of emergency services required after the sudden onset of a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

A) placing the non-citizen's health in serious jeopardy;

B) serious impairments to bodily functions; or

C) serious dysfunction of any organ or part (42 USC 1396(b)(v)).

(Source: Amended at 29 Ill. Reg. _____, effective September 30, 2005)

Section 120.311 Residence

a) Only those persons who are legally admitted to the United States can be found to be residents of the State of Illinois.

b) In order to be eligible an individual must be a resident of Illinois, but does not require actual physical presence within the State.

c) An individual is a resident of Illinois if living in Illinois (as defined by Section 2-10 of the Illinois Public Aid Code, Ill. Rev. Stat. 1983, ch. 23, par. 2-10) or if living in an out-of-state institution (as defined at 42 CFR 435.403(b)(1984))and was placed there by an Illinois Agency unless:

1) the individual maintains a house, apartment or other home in another State; or

2) the individual voluntarily leaves the out-of- state institution in which the individual was placed by an Illinois agency and does not return to Illinois; or

3) the individual is receiving a State Supplementary Payments (as defined at 42 CFR 435.4 (1984), Mandatory State Supplement or Optional State Supplement) from another State as a resident of that State; or

4) the individual was placed in an institution located in Illinois by another State.

d) An out-of-State Title IV-E eligible adoption assistance/foster care child living in Illinois is considered an Illinois resident for medical assistance coverage.

e) An Illinois resident who is temporarily absent from the State retains Illinois residency if the individual intends to return to Illinois when the reason for the absence is accomplished. If an individual remains outside of Illinois for a continous period of more than twelve (12) months, he/she must provide evidence (e.g. a copy of his/her most recent State Income Tax return) documenting that the absence was not due to an intent to change his/her residency.

(Source: Amended at 12 Ill. Reg. 6234, effective March 22, 1988)

Section 120.312 Age

a) There is no age requirement for the Aid to the Aged, Blind or Disabled (Blind) (AABD(B)) and Aid to the Aged, Blind or Disabled (Disabled) (AABD(D)) Medical Assistance - No Grant (MANG) programs.

b) An individual must be 65 year of age or older to qualify for Aged, Blind or Disabled (Aged) (AABD(A)) - Medical Assistance - No Grant (MANG).

c) To be designated as or to receive medical assistance as a caretaker relative in an AFDC-MANG case there is no minimum or maximum age requirement.

d) To be included in an AFDC-MANG case as a dependent child, a child must be under age 18 or age 18 and a full time high school senior (or equivalent level) and will finish school before reaching age 19.

e) If an individual receives medical assistance as a caretaker relative in an AFDC-MANG case that individual shall not be considered as a child in the determination of the of the medical assistance standard.

(Source: Amended at 7 Ill. Reg. 8264, effective July 5, 1983)

Section 120.313 Blind

MANG(B)

a) To be eligible for medical assistance as a blind person an individual must be determined blind as currently defined by the Social Security Administration (SSA). (See 20 CFR 416, Subpart I, April 1, 1984).

b) If an individual is receiving Supplemental Security Income (SSI) or primary Social Security (OASDI) benefits, the Department shall accept the Social Security Administration determination of blindness. The Department will make the determination when the client has been denied SSI on the basis of too much income or when the client is applying for medical assistance only and not receiving SSI or OASDI. The Department uses the same criteria for blindness as is used under SSI. (See 20 CFR 416, Subpart I, April 1, 1984).

c) 1) If an individual applying for or receiving medical assistance is determined currently "not blind" by SSA under the SSI or primary OASDI programs, the Department shall accept SSA's determination of blindness and deny or cancel the case, no matter which agency made the original determination of eligibility.

2) If the individual appeals the SSA determination of blindness to SSA, medical assistance shall be continued for recipients through the level of a determination by an Administrative Law Judge (ALJ) subject to the time limits of c)3) below. If medical assistance has been cancelled but the client later appeals to SSA, the case shall be reinstated through the ALJ level subject to the time limits of c)3) below.

3) If the client notifies the Department of his appeal to SSA within 10 days of the date of the Department notice, medical assistance will be continued with no break. If the client notifies the Department of his appeal to SSA within 11 through 65 days of the date of the Department notice, medical assistance will be reinstated back to the original date of cancellation. If the client notifies the Department of his appeal to SSA more than 65 days after the date of the Department notice, medical assistance will be provided prospectively only, unless the client actually appealed to SSA within 65 days of the date of the Department notice, in which case medical assistance will be reinstated back to the original date of cancellation.

4) Medical assistance shall not be provided to applicants for medical assistance through the SSA appeals process.

5) If an Administrative Law Judge finds the individual "not blind", the Department shall accept that finding as final. The individual shall not have the right to appeal the determination of blindness to the Department at any time during this process.

d) Redetermination of blindness is a condition of continuing eligibility for individuals who are not applying for or receiving SSI or OASDI benefits.

e) When appropriate, the Department shall pay for a medical examination to determine

blindness.

(Source: Amended at 8 Ill. Reg. 6770, effective April 27, 1984)

Section 120.314 Disabled

MANG(D)

a) To be eligible for medical assistance as a disabled person an individual must be determined disabled as currently defined by the Social Security Administration. (See 20 CFR 416, Subpart I, April 1, 1984.)

b) If an individual is receiving Supplemental Security Income (SSI) or primary Social Security (OASDI) benefits, the Department shall accept the Social Security Administration determination of disability. The Department will make the determination when the client has been denied SSI on the basis of too much income or when the client is applying for medical assistance only and not receiving SSI or OASDI. The Department uses the same criteria for disability as is used under SSI. (See 20 CFR 416, Subpart I, April 1, 1984).

c) If a child was terminated from SSI due to the August 22, 1996, change in disability standards (Public Law 104-193), and the child was eligible for both Medicaid and SSI on August 22, 1996, the child is considered disabled unless:
   1) the child becomes 18, or
   2) the child has not received Medicaid for 12 months, or
   3) the child no longer meets the pre-August 22, 1996, definition of disability.

d) Appeals
   1) If an individual applying for or receiving medical assistance is determined currently "not disabled" by SSA under the SSI or primary OASDI programs, the Department shall accept SSA's determination of disability and deny or cancel the case, no matter which agency made the original determination of eligibility.
   2) If the individual appeals the SSA determination of disability to SSA, medical assistance shall be continued for recipients through the level of a determination by an Administrative Law Judge (ALJ) subject to the time limits of subsection (d)(3) of this Section. If medical assistance has been canceled, but the client later appeals to SSA, the case shall be reinstated through the ALJ level subject to the time limits of subsection (d)(3) of this Section.
   3) If the client notifies the Department of his or her appeal to SSA within ten days after the date of the Department notice, medical assistance will be continued with no break. If the client notifies the Department of his or her appeal to SSA within 11 through 65 days after the date of the Department notice, medical assistance will be reinstated back to the original date of cancellation. If the client notifies the Department of his or her appeal to SSA more than 65 days after the date of the Department notice, medical assistance will be provided prospectively only, unless the client actually appealed to SSA within 65 days after the date of the Department notice, in which case medical assistance will be reinstated back to the original date of cancellation.
   4) Medical assistance shall not be provided to applicants for medical assistance

through the SSA appeals process.

5) If an Administrative Law Judge finds the individual "not disabled", the Department shall accept that finding as final. The individual shall not have the right to appeal the determination of disability to the Department at any time during this process.

e) Redetermination of disability is a condition of continuing eligibility for individuals who are not applying for or receiving SSI or OASDI benefits.

f) When appropriate, the Department shall pay for a medical examination to determine disability.

(Source: Amended at 22 Ill. Reg. 19875, effective October 30, 1998)

Section 120.315 Relationship

MANG(C)

a) The child(ren) must be living with a blood relative, step-relative or adoptive relative in the relative's home.

b) The required relationship does not exist between a child born-out-of-wedlock and the child's father or the father's relatives unless:

1) paternity has been adjudicated;

2) the father has acknowledged paternity in open court or by notarized written statement within the last two years; or

3) the father has contributed to the child's support within the last two years and had previously acknowledged paternity in open court or by notarized written statement.

c) A child conceived or born-in-wedlock is presumed to be the child of the marriage in the absence of a court finding to the contrary.

d) When the required relationship exists between the child and the relative, the relative is referred to as a specified relative.

Section 120.316 Living Arrangement

All persons included in the assistance unit must be residing in the same household. To be included in the assistance unit as a child, the child must live with a specified relative in that relative's home. The realtive must exercise primary responsibility for care and supervision of the child, even though either the child or the relative is temporarily absent from the customary family setting.

Section 120.317 Supplemental Payments

a) MANG(AABD)
State Supplemental Payments (SSP) shall be available to supplement the income of those individuals whose age, disability, or blindness would (apart from consideration of income) satisfy the eligibility factors of the Federal SSI program. Eligibility shall not exist if SSI payments would be higher in the absence of the SSP payments, or if the individual refuses or neglects to make application for assistance from SSI when so directed by the Department. Receipt of SSI is not a requirement of eligibility for SSP. Having made application for SSI benefits is an eligibility requirement for receipt of SSP; however denial of the SSI application does not preclude ineligibility for SSP unless SSI was denied due to a finding of "not aged", "not blind" or "not disabled". An individual determined by SSA as not aged, blind or disabled, is not eligible for SSP.

b) MANG(C)
An individual who is eligible for either MANG(C) or SSP shall have a choice between the two programs. In no instance may that individual receive both MANG(C) and SSP.

Section 120.318 Institutional Status

a) Individuals residing in public insititutions (see 42 CFR 435.1009) are ineligible for medical assistance.

b) Individuals between the ages of 22-64 who are patients in an Institution for Mental Diseases (see 42 CFR 435.1009) are ineligible for financial and medical assistance. These individuals continue to be ineligible for financial and medical assistance while temporarily discharged for the purpose of obtaining medical care. Individuals who are temporarily discharged remain patients of the institution as long as they are not given a complete or absolute discharge while they receive medical care. An individual on conditional release or convalescent leave from an Institution for Mental Diseases is not considered to be a patient in that institution. A conditional release or convalescent leave is one that provides treatment for the illness or condition for which the individual was institutionalized rather than for a medical condition.

c) Individuals confined in any local, state, or federal, penal or correctional institution, are ineligible for assistance.

d) Residents of a private psychiatric hospital certified for participation in the Medicare Program who are 65 years of age or older may be eligible for assistance. Those individuals residing in a private psychiatric hospital not certified to participate in the Medicare Program are not eligible for public assistance.

e) Individuals under age 21 residing in a private psychiatric hospital having JCAH accreditation may be eligible for public assistance.

f) A resident of a private institution who has a contract with the institution providing total needs throughout life is ineligible, as no needs remain to be met.

g) Residents of private institutions (other than those who have purchased life care contracts) are ineligible for public assistance when they have purchased care and maintenance to provide for all their needs in the institution and the amount paid has not been wholly consumed for care.

h) Individuals, living in a public or a private facility which has official policies and administrative procedures which are not in conformance or are in conflict with the Public Aid Code provision or Department rules governing eligibility for public assistance, are ineligible for public assistance.

i) Any individual residing in a facility which is licensed by the Department of Public Health as a Community Living Facility for the mildly and moderately retarded may be eligible for MANG.

(Source: Amended at 18 Ill. Reg. 2051, effective January 21, 1994)

Section 120.319 Assignment of Rights to Medical Support and Collection of Payment

a) Assignment of Rights to Medical Support
   1) By accepting medical assistance under the Public Aid Code (Ill. Rev. Stat. 1989, ch. 23, par. 5-2), a custodial relative, spouse, or a parent shall be deemed to have made assignment to the Department of any and all rights, title, and interest in any medical support obligations up to the amount of medical assistance provided (Ill. Rev. Stat. 1989, ch. 23, par. 10-1). The rights to medical support assigned to the Department shall constitute an obligation owed to the State by the person who is responsible for providing the support and is collectable under all available processes.
   2) This right includes the rights of any individual or any other person who is eligible for medical assistance and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purposes of medical care by a court or administrative order) and to a payment for medical care from any third party.

b) To enforce and collect these payments, the State Medicaid agency may enter into cooperative agreements with the State IV-D agency (i.e., the Division of Child Support Enforcement within the Department of Public Aid) and other appropriate agencies, courts and law enforcement officials, to assist in making collections.

c) Amounts of medical support or third party payments collected under this assignment shall be retained by the Department as necessary, to reimburse the Department for medical assistance payments made on behalf of an individual for whom an assignment was executed. Any remaining amount of such collection shall be paid to the individual who executed the assignment.

d) When an individual is no longer receiving medical assistance the assignment of medical support rights terminates except for any medical support owed to the Department for the period of time medical assistance was issued.

(Source: Amended at 16 Ill. Reg. 1862, effective January 20, 1992)

Section 120.320 Cooperation in Establishing Paternity and Obtaining Medical Support

a) In accordance with 89 Ill. Adm. Code 160.30, as a condition of eligibility for medical assistance a caretaker relative or spouse included in the assistance unit, who assigned to the Department his/her rights to medical support, shall cooperate with the Department in:
   1) establishing the paternity of a child born out of wedlock, for whom the individual can legally assign rights; and
   2) obtaining medical support and payments on his or her own behalf and on behalf of those persons for whom the client has assigned rights.

b) Cooperating with the Department in establishing paternity and obtaining medical support payments includes:
   1) appearing at such places as the Department's offices or the offices of the Department's legal representative, as necessary, to provide information or evidence, known to, possess by or reasonably obtainable by the client (e.g. identity/location of the legally responsible relative, or identity/location of a third party who has information regarding the legally responsible relative), or attest to the lack of information under penalty of perjury;
   2) appearing and testifying as a witness at judicial proceedings;
   3) paying to the Department any medical support payments or third party payments for medical care; and
   4) taking any other reasonable steps to assist in establishing paternity and securing medical support and payments (e.g. signing legal documents (complaints), submitting to blood tests).

c) 1) If the caretaker and his/her spouse are in the home and included in the assistance unit, both must comply with the cooperation requirements unless the Department determines the individual is exempt from cooperation for good cause. A caretaker relative or spouse who fails or refuses without good cause, to cooperate in establishing paternity or securing medical support, shall be excluded from the medical assistance unit.
   2) The remaining eligible assistance unit members, shall be authorized medical assistance through a representative payee, until such time as the person meets the cooperation requirement. A representative payee is a specified relative in all cases other than those listed in 89 Ill. Adm. Code 117.10.

(Source: Amended at 16 Ill. Reg. 1862, effective January 20, 1992)

Section 120.321 Good Cause for Failure to Cooperate in Establishing Paternity and Obtaining Medical Support

a) The Department shall inform the caretaker relative of his/her right to claim an exemption from cooperation, based on a claim of good cause.

b) With respect to claiming good cause for exemption as not in the best interests of a child for whom an assignment was executed, the Department's Good Cause policy at 89 Ill. Adm. Code 160.35, shall apply.

c) With respect to claiming good cause for exemption as not in the best interests of the caretaker relative or any individual other than the child for whom an assignment was executed, the Department's Good Cause policy at 89 Ill. Adm. Code 160.35, shall apply excluding those parts applicable only to children.

(Source: Amended at 16 Ill. Reg. 1862, effective January 20, 1992)

Section 120.322 Proof of Good Cause for Failure to Cooperate in Establishing Paternity and Obtaining Medical Support

a) With respect to the caretaker relative proving/ documenting a claim of good cause as not in the best interest of the child, the Department's Proof of Good Cause policy at 89 Ill. Adm. Code 160.40, shall apply.

b) With respect to the caretaker relative proving/ documenting a claim of good cause as not in the best interest of a person other than a child, the Department's Proof of Good Cause policy at 89 Ill. Adm. Code 160.40, shall apply, excluding those parts applicable only to children.

(Source: Amended at 16 Ill. Reg. 1862, effective January 20, 1992)

Section 120.323 Suspension of Paternity Establishment and Obtaining Medical Support Upon Finding Good Cause

a) Upon a caretaker relative's claim of good cause, the Department will suspend all activities to establish paternity or secure medical support payments until a final determination is made on the good cause claim.

b) The Department shall not undertake to establish paternity or secure medical support payments when the Department determines that good cause for exemption exists.

c) This suspension shall be in accordance with 89 Ill. Adm. Code 160.45, Suspension of Child Support Enforcement Upon Finding of Good Cause.

(Source: Amended at 16 Ill. Reg. 1862, effective January 20, 1992)

Section 120.324 Health Insurance Premium Payment (HIPP) Program

a) This program provides health insurance coverage for recipients who have health insurance available and have high cost medical expenses. Authorization for the Health Insurance Premium Payment Program (HIPP) was established by Section 4402 of OBRA 1990 which added Section 1906 to the Social Security Act.

b) Program Provisions

1) The HIPP Program shall provide for the mandatory enrollment of eligible persons in available cost effective group or individual health plans as a condition of medical assistance eligibility. A group health plan is "any plan of, or contributed to by, an employer (including a self insured plan) to provide health care to the employer's employees, former employees, or families of such employees or former employees." An individual health plan is a contract for health insurance coverage between an individual and an insurance company.

2) The Department shall pay health insurance premiums for eligible medical assistance recipients whenever it is likely to be cost effective.

c) Program Standards

1) The HIPP program shall be limited to persons otherwise eligible for medical assistance (excluding spenddown and long term care clients) who have high cost medical conditions such as, but not limited to:

A) Severe arthritis;
B) Cancer;
C) Heart ailment or defect;
D) Liver disease or dysfunction;
E) Kidney disease or dysfunction;
F) Brain disease or disorder;
G) Neurological disease or disorder;
H) Diabetes;
I) Acquired Immune Deficiency Syndrome (AIDS);
J) Organ transplant; and
K) Any other medical condition requiring high cost ongoing medical treatment.

2) To be eligible for medical assistance, a client with a high cost medical condition who can enroll in a group or individual health plan must supply information about the health plan. The client must enroll (or re-enroll) if:

A) the client can enroll on his or her own behalf, and
B) the plan covers the client's high cost medical condition, and
C) the plan is determined by the Department to be cost effective.

3) A client that fails to enroll in a cost effective health plan, is ineligible for medical assistance until the next enrollment period and proof of enrollment is provided.

4) Determination of the cost effectiveness shall be made by the Department on a

case by case basis using prior medical history.

5) Cost effective means the average cost of medical services for the period of time covered by the health insurance premium is greater than twice the premium cost for the period.

6) The Department will notify the client that enrollment is necessary because the plan is cost effective. The client will have the right to appeal this determination according to the rules in 89 Ill. Adm. Code 102.80.

7) When the policy covers other family members only the client's share of the premium will be paid by HIPP unless retention of the policy is contingent upon paying premiums for other medical assistance eligible recipients.

8) Payment of premiums for a non-eligible family member may be made if necessary to enroll the HIPP participant. A non-eligible family member may reside in another household. Deductibles and co-insurance shall not be paid for the non-eligible family members. Premiums shall not be paid if the non-eligible family member is required to enroll dependent(s) through a divorce order or order for medical support.

9) Health insurance premiums may be paid directly to employers, unions or insurance companies.

10) Clients paying their own premiums shall be reimbursed only if premium payments are made through payroll deduction or the client has already paid the premium. Reimbursement of premium shall only be made after the client accumulates a minimum of $50.00 in payments and submits proof of payment.

11) HIPP shall pay deductibles and co-payments based on the Department's medical payment standards.

12) Medical assistance payments shall be made for items and services covered under the Medical Assistance Program which are not covered by the health plan.

13) Premium payments may be made prior to case approval or certification only when it appears likely that the case will be approved or certified and timely payment or enrollment is crucial to the retention of coverage.

14) Assignment of medical support rights provisions shall apply to any health insurance premium for which the Department pays or reimburses the client. If the client receives a return of premium, for any reason, from the insurance carrier, the returned premium must immediately be turned over to the Department, or be subject to recovery.

15) Insurance payments for medical services shall be assigned to the medical provider at the time the services are requested. In the event a client receives an insurance payment for medical services which were also paid by the Department, the client must immediately turn the payment over to the Department, or be subject to recovery.

(Source: Section repealed, new Section adopted at 18 Ill. Reg. 5934, effective April 1, 1994)

Section 120.325 Health Insurance Premium Payment (HIPP) Pilot Program

a) The pilot program will begin on January 1, 1994 and will operate for a minimum of three (3) months.
b) The pilot program will be conducted in Auburn Park, Peoria and Winnebago Local Offices.
c) The rules for the pilot program are in Section 120.324, Health Insurance Premium Payment Program.

(Source: Section repealed, new Section adopted at 18 Ill. Reg. 5934, effective April 1, 1994)

Section 120.326 Foster Care Program

a) A child is eligible for MANG(C) when:
   1) The child has been removed from the home of a specified relative as a result of court action, is a child for whom DCFS is legally responsible, and has been placed in foster care (foster care home, or private non-profit, group home institution) which is licensed or approved by the Department of Children and Family Services; and
   2) The child was eligible for and receiving MANG(C) in or for the month in which court action was initiated leading to placement; or
   3) The child met the citizenship, age, residence, need, and lack of parental support or care criteria for MANG(C) at the time of initiation of court action and lived with a specified relative at any time within the six (6) months prior to the initiation of court action leading to placement; and
   4) The child continues to meet AFDC eligibility requirements of age, need, lack of parental support or care, and registration/participation requirements.

b) An application for AFDC-F must be signed by an authorized representative of the Department of Children and Family Services.

c) Assistance under the AFDC-F program is effective from the latter of the date:
   1) that a completed application is received by the Department; or
   2) the child is actually placed in foster care.

d) A foster parent who is a specified relative of an eligible foster child placed in the foster parent's care may receive assistance for the child under either the AFDC-R/AFDC-U or the AFDC-F program.

(Source: Added at 18 Ill. Reg. 5934, effective April 1, 1994)

Section 120.327 Social Security Numbers

a) To be eligible for AABD or AFDC MANG, each individual must furnish the Department his/her Social Security Number(s) (SSN). If more than one SSN has been assigned to any individual(s), all numbers are to be furnished.

b) If a SSN cannot be furnished, either because it has not been issued or is not known, application shall be made for a SSN.

c) Medical assistance will not be denied, delayed or discontinued pending the issuance or validation of a SSN if the individual, or someone acting responsibly for the individual, applies for the SSN.

d) Individuals for whom a SSN is not furnished and for whom application for a SSN is not made are ineligible for medical assistance under the AABD or AFDC MANG program.

(Source: Added at 18 Ill. Reg. 5934, effective April 1, 1994)

Section 120.330 Unearned Income

a) All currently available, unearned income which is not specified as exempt shall be considered in the determination of eligibility.

b) Unearned income is all income other than that received in the form of salary for services performed as an employee or profits from self-employment. Unearned income includes any amount of interest earned from assets disregarded by Section 120.382(a)(3) and (a)(4).

c) When the amount of unearned income to be considered is determined, the cents are dropped from each payment amount.

d) For payments received weekly, the weekly amount is multiplied by 4.33 to determine the countable monthly income.

e) For payments received bi-weekly, the bi-weekly amount is multiplied by 2.16 to determine the countable monthly income.

(Source: Amended at 21 Ill. Reg. 13638, effective October 1, 1997)

Section 120.332 Budgeting Unearned Income

Monthly unearned income of a client is budgeted on the basis of income anticipated to be received during the budgeting period. Computation is to be based on information provided by the client and verification of that information. All income is to be converted into monthly amounts. Budgeting occurs upon initial determination, upon redetermination and when the client reports a change in the source or amount of income received.

(Source: Amended at 3 Ill. Reg. 3, p. 399, effective August 18, l979)

Section 120.335 Exempt Unearned Income

a) MANG (AABD)
   1) For a MANG client (excluding long term care), the first $25.00 of a client's earned or unearned income other than SSI income, or contributions from a spouse or other individual, is exempt from consideration in determining eligibility. A client is eligible for only one $25.00 exemption regardless of the types of sources of earned or unearned income.
   2) If an individual in a long term care facility is paying the premium for SMIB coverage, the cost of the premium shall be disregarded.
   3) SSI income received by a long term care case who is in Section 1619 of the Social Security Act (42 U.S.C. 1382h) status (see 89 Ill. Adm. Code 140.8) in the month before admission to the facility is exempt for the first full two months of stay in the facility.

b) The following unearned income shall be exempt from consideration in determining MANG eligibility:
   1) The value of the coupon allotment under the Food Stamp Act of 1977 (7 U.S.C. 2017(b));
   2) The value of the U.S. Department of Agriculture donated foods (surplus commodities);
   3) Any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (42 U.S.C. 4636);
   4) Any per capita judgment funds paid under P.L. 92-254 to members of the Blackfeet Tribe of the Blackfeet Indian Reservation, Montana and the Gros Ventre Tribe of the Fort Belknap Reservation, Montana (25 U.S.C. 1264);
   5) Any benefits received under Title III, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended (42 U.S.C. 3030e);
   6) Any compensation provided to individual volunteers under the Retired Senior Volunteer Program and the Foster Grandparent Program and Older Americans Community Service Programs established under Title II of the Domestic Volunteer Service Act, as amended;
   7) Income in an amount not greater than $650 received by a beneficiary of life insurance which is expended on the funeral and burial of an insured recipient;
   8) Income received under the provisions of Section 4(c) of the Illinois Senior Citizens and Disabled Persons Property Tax Relief and Pharmaceutical Assistance Act (Ill. Rev. Stat. 1989, ch. 67 1/2, par. 404 (c)). This includes both the benefits commonly known as the circuit breaker and "additional grants";
   9) Payments to volunteers under the 1973 Domestic Volunteer Service Act. (48 U.S.C. 5044 (q)) These include:
      A) Vista Volunteers;
      B) Volunteers serving as senior health aids, senior companions, or foster grandparents;

C) Persons serving in the Service Corps of Retired Executives (SCORE) or the Active Corps of Executives (ACE); and

l0) Unearned income such as need based payments, cash assistance, compensation in lieu of wages and allowances received through the Jobs Training Partnership Act.

c) The following additional unearned income shall be exempt:

1) Social Security death benefit expended on a funeral and/or burial.

2) The value of home produce which is used for personal consumption.

3) The value of supplemental food assistance received under the Child Nutrition Act of 1966, as amended, (42 U.S.C. 1780(b)) and the special food service program for children under the National School Lunch Act, as amended (42 U.S.C. 1760).

4) Any payments distributed per capita or held in trust for members of any Indian Tribe under P.L. 92-254, P.L. 93-134 or P.L. 94-450 (25 U.S.C. 1407).

5) Tax exempt portions of payments made pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. 1626).

6) Experimental Housing Allowance Program payments made under Annual Contributions Contracts entered into prior to January 1, 1975 under Section 23 of the U.S. Housing Act of 1937, as amended (42 U.S.C. 1437 (f)).

7) The first $50 of the total child support payments received each month on behalf of the assistance unit members. The amount of up to $50 exempted is based on the total child support received in a month, regardless of the number of parents who contribute. Both court ordered and voluntary payments are considered when exempting the first $50 of child support payments.

8) A Title IV-E adoption assistance payment or foster care payments received from a state welfare agency of another state.

9) Income from a trust fund established under the Self Sufficiency Trust Fund Program (Section 5-118 of the Mental Health and Developmental Disabilities Code, Ill. Rev. Stat. 1989, ch. 91 1/2, par. 5-118).

10) Payments made to veterans who receive an annual disability payment or to the survivors of deceased veterans who receive a one-time lump sum payment from the Agent Orange Settlement Fund or any other fund referencing Agent Orange product liability under P.L. 101-201.

11) Payments made by the Illinois Department of Mental Health and Developmental Disabilities under the Family Assistance Program for Mentally Disabled Children under P.A. 86-921.

12) Payments received from a fund established by a State to aid victims of crime.

(Source: Amended at 15 Ill. Reg. 12747, effective August 16, 1991)

Section 120.336 Education Benefits

The following education benefits shall be exempt:

a) Veterans Educational Assistance
Income from educational benefits paid to a veteran or to a dependent of a veteran.

b) Social Security Administration Benefits
Income received as an SSA benefit paid to or for an individual and conditioned upon the individual's regular attendance in a school, college or university, or a course of vocational or technical learning.

c) All other education grants and loans.

(Source: Amended at 28 Ill. Reg. 4701, effective March 3, 2004)

Section 120.338 Incentive Allowance

The following incentive allowances shall be exempt:

a) National Training Services Grant
Incentive payments which the Division of Vocational Rehabilitation authorizes to be paid to disabled persons receiving categorical assistance and enrolled in the National Training Service Project.

b) Work Incentive Demonstration Progam (WDP) Incentive Payments.

(Source: Amended at 8 Ill. Reg. 13328, effective July 16, l984)

Section 120.340 Unearned Income In-Kind

a) Unearned Income in-kind is payment made by a non-member of the assistance unit in behalf of or in the name of a member of the assistance unit.
b) Unearned income in-kind shall be exempt.
c) When the assistance unit shares a dwelling unit with another family or individual(s), the exchange of cash for purposes of satisfying payment of shelter related obligations shall not constitute an income in-kind payment and shall not be considered available to meet the needs of the person who receives and disburses the shelter-related payment.

(Source: Amended at 3 Ill. Reg. 33, p. 399, effective August l8, l979)

Section 120.342 Child Support and Spousal Maintenance Payments

a) Court ordered child support and/or spousal maintenance (alimony) payments shall be deducted from nonexempt income in determining the countable income of the person making the payment.

b) Voluntary child support and/or spousal maintenance payments made for persons for whom the payer is legally responsible according to 89 Ill. Adm,. Code 103.10 shall be deducted from nonexempt income in determining the countable income of the responsible relative.

c) These deductions cannot exceed the total amount of countable income.

(Source: Amended at 26 Ill. Reg. 9846, effective June 26, 2002)

Section 120.345 Earmarked Income

a) Earmarked income is income restricted for the use of a specified individual by court order, or by legal stipulation of a contributor.

b) MANG(AABD)
Earmarked income shall be budgeted against the needs of the specified individual only.

c) MANG(C)
Earmarked income shall be considered available to meet the family's needs. The caretaker relative may request that any individual receiving earmarked income sufficient to meet that individial's need be deleted from the assistance unit. In that instance, the earmarked income shall be considered available to meet the needs of the deleted individual and the needs of person(s) for whom the individual is legally responsible.

(Source: Amended at 3 Ill. Reg. 33, p. 399, effective August 8, l979)

Section 120.346 Medicaid Qualifying Trusts

a) This Section applies to trusts established prior to August 11, 1993.

b) The maximum amount of payment permitted under the terms of a Medicaid qualifying trust (described in subsection (c) below) shall be considered in determining eligibility for medical assistance, whether or not the maximum amount was distributed to the individual. The maximum amount is considered in determining eligibility for medical assistance, whether or not the trust is irrevocable or established for reasons other than to qualify for Medicaid.

c) A Medicaid qualifying trust is a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

(Source: Amended at 19 Ill. Reg. 2905, effective February 27, 1995)

Section 120.347 Treatment of Trusts

a) This Section applies to trusts established on or after August 11, 1993.

b) A trust is any arrangement in which a grantor transfers property to a trustee or trustees with the intention that it be held, managed or administered by the trustee or trustees for the benefit of the grantor or designated beneficiaries. A trust also includes any legal instrument or device that is similar to a trust, including an annuity.

c) A person shall be considered to have established a trust if assets of the person were used to form all or part of the principal of the trust and the trust is established (other than by will) by any of the following:
   1) the person;
   2) the person's spouse; or
   3) any other person, including a court or administrative body, with legal authority to act on behalf of or at the direction of the person or the person's spouse.

d) This Section does not apply to the following trusts:
   1) an irrevocable trust containing assets of a disabled person (as described in Section 120.314) under age 65 that is established by a parent, grandparent, legal guardian or court for the benefit of the disabled person, if language contained in the trust stipulates that any amount remaining in the trust (up to the amount expended by the Department on medical assistance) shall be paid to the Department upon the death of the person. This exclusion continues after the person reaches age 65 as long as the person continues to be disabled but any additions made by the person to the trust after age 65 will be treated as a transfer of assets under Section 120.387. If the trust contains proceeds from a personal injury settlement, any Department charge (as described at 89 Ill. Adm. Code 102.260) must be satisfied in order for the trust to be excluded under this subsection; or
   2) an irrevocable trust containing assets of a disabled person (as described in Section 120.314) that is established and managed by a non-profit association that pools funds but maintains a separate account for each beneficiary that is established by the disabled person, a parent, grandparent, legal guardian or court for the benefit of the disabled person, if language contained in the trust stipulates that any amount remaining in the trust (up to the amount expended by the Department on medical assistance) that is not retained by the trust shall be paid to the Department upon the death of the person. If the trust contains proceeds from a personal injury settlement, any Department charge (as described at 89 Ill. Adm. Code 102.260) must be satisfied in order for the trust to be excluded under this subsection (d).

e) Subsections (f) and (g) of this Section apply to the portion of the trust attributable to the person and without regard to:
   1) the purpose for establishment of the trust;
   2) whether the trustee has or exercises any discretion under the trust; or

3) whether there are any restrictions on distributions or use of distributions from the trust.

f) For revocable trusts, the Department shall:
1) treat the principal as an available asset;
2) treat as income payments from the trust that are made to or for the benefit of the person; and
3) treat any other payments from the trust as transfers of assets by the person (subject to the provisions of Section 120.387).

g) For irrevocable trusts, the Department shall:
1) treat as an available asset the amount of the trust from which payment to or for the benefit of the person could be made;
2) treat as income payments from the trust that are made to or for the benefit of the person;
3) treat any other payments from the trust as transfers of assets by the person (subject to the provisions of Section 120.387); and
4) treat as a transfer of assets by the person the amount of the trust from which no payment could be made to the person under any circumstances (subject to the provisions of Section 120.387). The date of the transfer is the date the trust was established or, if later, the date that payment to the person was foreclosed. The amount of the trust is determined by including any payments made from the trust after the date that payment to the person was foreclosed.

(Source: Amended at 22 Ill. Reg. 16291, effective August 28, 1998)

Section 120.350 Lump Sum Payments and Income Tax Refunds

a) Lump sum payments shall be considered available for the established six month period in which it is received.

b) For a MANG client who resides in the community, SSI lump sum payments are exempt income. SSI lump sum payments that are kept separately and are not combined with other monies remain exempt.

c) For a MANG client who resides in a group care facility, DMHDD facility or other medical facility, SSI lump sum payments are considered non-exempt income. The lump sum payment is considered available to meet the needs of the individual for the established six month period in which it is received.

(Source: Amended at 7 Ill. Reg. 394, effective January 1, 1983)

Section 120.355 Protected Income

a) MANG(AABD)
   1) Supplemental Security Income (SSI) is protected income and not considered available to meet the needs of any other person.
   2) For a MANG client who resides in the community, SSI lump sum payments are exempt income. SSI lump sum payments that are kept separately and are not combined with other monies remain exempt.
   3) For a MANG client who resides in a group care facility, DMHDD facility or other medical facility, SSI lump sum payments are considered non-exempt income. The lump sum payment is considered available to meet the needs of the individual for the established six month period in which it is received.

b) MANG(C)
   All income and assets of a Supplemental Security Income (SSI) beneficiary shall be protected and shall not be considered available to meet the needs of any MANG(C) applicant or recipient.

(Source: Amended at 5 Ill. Reg. 8041, effective July 27, 1981)

Section 120.360 Earned Income

a) All currently available income which is not specified as exempt is considered in the determination of eligibility.

b) Earned income is remuneration acquired through the receipt of salaries or wages for services performed as an employee or profits from an activity in which the individual is self-employed.

c) AFDC (MANG)

1) Earned income received through the Job Training Partnership Act by dependent children who are full-time students or who are part-time students and not employed full-time (i.e., working 100 hours or more per month) is exempt (see 89 Ill. Adm. Code 112.140 for a definition of "full-time student" and "part-time student"). Participants in Job Corps are considered students.

2) Earned income received through the Job Training Partnership Act by dependent children who are not students as described in subsection (c)(1) of this Section is exempt for six months each year.

d) AABD (MANG)

Earned income received through the Job Training Partnership Act must be budgeted against the AABD MANG standard.

e) When the amount of earned income to consider is determined, the cents are dropped from each payment amount.

(Source: Amended at 20 Ill. Reg. 15993, effective December 9, 1996)

Section 120.361 Budgeting Earned Income

a) Budgeting is the method by which nonexempt income is compared to the applicable MANG Standard (as contained in Sections 120.20, 120.30 and 120.31).
b) For persons who are paid weekly, the average gross weekly payment is multiplied by 4.33 to determine the countable gross monthly income.
c) For persons who are paid bi-weekly, the average gross bi-weekly payment is multiplied by 2.16 to determine the countable gross monthly income.

(Source: Amended at 20 Ill. Reg. 15993, effective December 9, 1996)

Section 120.362 Exempt Earned Income

a) MANG (AABD) (Excluding Long Term Group Care)
The first $25.00 of a client's earned or unearned income, other than SSI or contributions from a spouse or other individual residing outside the home, is exempt from consideration in the determination of eligibility. A client is eligible for only one $25.00 exemption regardless of the type or source of income.

b) Certain additional amounts of earned income shall be exempt:
   1) For MANG (AABD(A)(D)), the first $20.00 of gross earned income and one-half of the next $60.00 are exempt.
   2) For MANG (AABD(B))
      A) The first $85.00 of the gross earned income and one-half of the amount in excess of $85.00 are exempt.
      B) Amounts of income as may be necessary for fulfillment of a client's plan for achieving self-support for a period not to exceed 12 months are exempt.

c) MANG(C)
Earned income shall be exempt if it is the earned income of an individual receiving assistance as a dependent child who is:
   1) A full-time student in a school (including vocational and technical) college or university approved by the Illinois Office of Education. Full time is defined as follows:
      A) High School - 25 clock hours per week or enrollment in a secondary education program of training which the school defines as full time attendance;
      B) Vocational or Technical School - 30 clock hours per week when the program involves shop practice; 25 hours per week when the program does not involve shop practice; or
      C) College or University - 12 semester or quarter hours.
   2) A part-time student who is not employed 100 hours per month or more.

(Source: Amended at 20 Ill. Reg. 15993, effective December 9, 1996)

Section 120.363 Earned Income Disregard - MANG(C)

The first $90.00 of earned income is disregarded from the monthly earned income of each employed person.

(Source: Added at 20 Ill. Reg. 15993, effective December 9, 1996)

Section 120.364 Earned Income Exemption

a) For MANG(C), the first $30.00 of the combined net earned income of each employed person excluding the earned income of a dependent child (see Sections 120.360 and 120.362) plus one-third of the remainder shall be exempt from consideration. The net income is gross income after the deduction of appropriate business expenses and/or employment expense.

b) After the amount of the earned income exemption is determined, the cents are dropped before the earned income exemption is deducted from the gross unearned income minus the income disregard.

(Source: Amended at 20 Ill. Reg. 15993, effective December 9, 1996)

Section 120.366 Exclusion From Earned Income Exemption

For MANG(C and CU) the earned income exemption applies:

a) l) If the individual has not already received the earned income exemption as an AFDC grant recipient for four (4) consecutive months; or

2) If an individual received the exemption as an AFDC grant recipient for four (4) consecutive months, he/she has not received AFDC grant assistance for l2 consecutive months since the last month of that four months, then the individual must meet one of the following conditions in order to receive the earned income exemption:

A) the individual's gross income minus the income disregards and self employment business expenses, plus all other nonexempt income, is less than the AFDC Standard of Need, or

B) the individual was an AFDC grant recipient in any one of the four months before the month for which the determination is made.

b) Unless any individual included in the assistance unit other than a dependent child:

1) Terminated employment or reduced earned income without good cause within the period of 30 days preceding such month, or

2) Refused without good cause, within the period of 30 days preceding such month, to accept employment in which the individual was able to engage and which has been determined to be a suitable, available offer of employment, or

3) Fails without good cause to report income in a timely manner.

(Source: Amended at 9 Ill. Reg. 7153, effective May 6, l985)

Section 120.370 Recognized Employment Expenses

a) MANG(AABD)

The following recognized expenses of employment shall be exempt from consideration for MANG(AABD):

1) Withholding taxes (Federal and State);
2) Social Security tax;
3) Transportation at most reasonable rate. If the individual's own car is the most economical means of transportation, l9 cents per mile shall be allowed as transportation expense;
4) Lunch supplementation:
   A) If carried from home, 15 cents per working day to a maximum of $3.00 per month;
   B) If purchased at work, 45 cents per working day to a maximum of $9.00 per month;
5) Special tools and uniforms required by employment;
*6) Union dues;
*7) Group life insurance premiums;
*8) Group health insurance premiums;
*9) Retirement plan withholding; and
10) The reasonable cost of items and services which are needed and used to enable a disabled person to work.

*Agency Note: Only if mandatory as a condition of employment

b) MANG(C)

1) For employment expenses, $90.00 shall be deducted from the gross earned income of each employed individual.
2) For earnings from self-employment and rental property, an amount equal to the expenses directly attributable to producing goods or services or an amount equal to the expenses of rental shall be deducted from income.
3) The employment expense allowance is not available to an individual for any month in the following situations:
   A) The individual terminated employment or reduced earned income without good cause within the period of 30 days preceding such month;
   B) The individual refused without good cause, within the period of 30 days preceding such month, to accept employment in which the individual was able to engage and which has been determined to be a sutiable, available offer of employment;
   C) The individual fails without good cause to report income in a timely manner; or
   D) The individual voluntarily requests AFDC assistance to be terminated to avoid receiving the 30 + l/3 exemption for four consecutive months. (See Section 120.362 through 120.365).

4) Child Care

A) Expenses of child care shall be deducted from income up to a maximum of $200.00 per child for each child under the age of two (2) and $175.00 for each child age two (2) and over.

B) The child care deduction is not allowed when the child care provider is a responsible relative (see 89 Ill. Adm. Code 103.10(b)) of the child receiving care.

(Source: Amended at 15 Ill. Reg. 11973, effective August 12, 1991)

Section 120.371 Income From Work/Study/Training Programs

a) Income from college work-study is considered exempt income.

b) AFDC (MANG)

1) Earned income received through the Job Training Partnership Act by dependent children who are full-time students or who are part-time students and not employed full-time (i.e. working 100 hours or more per month) is exempt (see 89 Ill. Adm. Code 112.140 for a definition of "part-time student" and "full-time student"). Participants in Job Corps are considered students.

2) Earned income received through the Job Training Partnership Act by dependent children who are not students as described in (1) above is exempt for six months each year.

c) AABD (MANG)

1) Earned income received through the Job Training Partnership Act must be budgeted against the AABD MANG standard.

2) Unearned income such as need based payment, cash assistance, compensation in lieu of wages and allowances received through the Job Training Partnership Act is exempt.

(Source: Amended at 8 Ill. Reg. 13328, effective July 16, l984)

Section 120.372 Earned Income From Self-Employment

a) Income realized from self-employment is considered earned income.

b) Accurate and complete records shall be kept on all monies received and spent through self-employment. If the individual fails or refuses to maintain complete business records, the assistance unit is ineligible.

c) Business expenses must be verified. The individual has full responsibility for proof of any business expense. No deduction is allowed for depreciation, obsolescence and/or similar losses in the operation of the business. Gross income from the business is turned back into the business only to replace stock actually sold.

d) The net income is the gross remaining after the replacement of stock and business expenses have been considered, and the appropriate employment expenses and child care expenses, as specified in Section 113, have been deducted. The earned income exemption, if applicable, is computed on the net income.

(Source: Amended at 21 Ill. Reg. 7423, effective May 31, 1997)

Section 120.373 Earned Income From Roomer and Boarder

a) MANG(AABD)
   1) Money paid by roomers and/or boarders to a member of an assistance unit who represents himself as being self-employed in the business of renting rooms shall be considered earned income.
   2) The following itmes shall be allowed as deductions for a roomer and boarder.
      A) Replacement of towels and bed linen - $l.50
      B) Laundry - 55¢ for additional supplies when the recipient launders the linen; or the roomer's per capita cost when laundry is done commercially
      C) Food - if the roomer and boarder receives public assistance, the allowance is the appropriate MANG(AABD) financial standard. If the roomer and boarder does not receive public assistance, the allowance is the appropriate MANG(AABD) standard plus 25% of the allowance
      D) Earned income exemptions as applicable.
   3) The applicable earned income exemption shall be the only deduction allowed for a roomer who is not also a boarder.

b) MANG(C)
   Money paid by roomers and/or boarders to a member of an assistance unit who holds himself out as being self-employed in the business of renting rooms shall be considered earned income.

(Source: Peremptory amendment at 5 Ill. Reg. 10095, effective October 1, 1981)

Section 120.375 Earned Income In-Kind

a) Earned income in-kind is remuneration received in a form other than cash for services performed. Such remuneration shall include, but is not limitated to housing, food (except meals provided while working), satisfaction of a debt, or a service provided by the employer for the employee.
b) Earned income-in-kind shall be exempt.

(Source: Amended at 5 Ill. Reg. 10733, effective October l, l98l)

Section 120.376 Payments from the Illinois Department of Children and Family Services

Foster Care Payments

a) The following foster care payments made by the Department of Children and Families Services (DCFS) are to be considered exempt unearned income when determining the eligibility of the assistance unit (exclusive of the foster child).
   1) Basic maintenance payments.
   2) Special service fee payments.
   3) Intensive service fee payments.
   4) Monthly retainer fee payments.
   5) Adoption Subsidies.

b) Independent living arrangement payments.
   Payments made by DCFS to wards living independently of a foster home shall be considered nonexempt unearned income when determining the eligibility of the ward's children for assistance.

(Source: Amended at 8 Ill. Reg. 5253, effective April 9, l984)

Section 120.379 Provisions for the Prevention of Spousal Impoverishment

a) The provisions for the prevention of spousal impoverishment apply only to a resident of a long term care facility whose spouse resides in the community and to a person who but for the provision of home and community-based services under Section 4.02 of the Illinois Act on the Aging would require the level of care provided in a long term care facility and whose spouse resides in the community.

b) An assessment is completed to determine the total combined amount of nonexempt assets of the individual and his or her community spouse:
   1) when residence begins in a long term care facility or when home and community-based services begin; and
   2) when requested by either spouse or a representative acting on behalf of either spouse, even if an application for assistance has not been filed.

c) A re-assessment is not required if:
   1) a resident of a long term care facility is discharged for a period of less than 30 days and then reenters the facility;
   2) a resident of a long term care facility enters a hospital and then returns to the facility from the hospital;
   3) an individual discontinues receiving home and community-based services for a period of less than 30 days; or
   4) an individual discontinues receiving home and community-based services due to hospitalization and then is discharged and begins to receive home and community-based services.

d) The transfer of property is allowed, as determined in subsection (b) of this Section, by the client to the community spouse or to another individual for the sole benefit of the community spouse in an amount that does not exceed the Community Spouse Asset Allowance (CSAA). The CSAA, as of October 1, 1989, is an amount up to but not greater than $60,000 that the individual may transfer, without affecting eligibility, to the community spouse or to another individual for the sole benefit of the community spouse. As of October 1, 1989, the amount of assets an individual may transfer to his or her community spouse is $60,000 minus any nonexempt assets of the community spouse. The amount established as the CSAA shall be provided for calendar years after 1989 by the Department of Health and Human Services. The CSAA may exceed the standard annual figure established by the U.S. Department of Health and Human Services only in one of the following circumstances:
   1) in a legal proceeding, a court approves the transfer of income-producing assets to the community spouse in an amount greater than the standard CSAA; or
   2) as the result of an appeal hearing (described in 89 Ill. Adm. Code 104.1), the Department determines that the transfer of income-producing assets to the community spouse in an amount greater than the standard CSAA is necessary to raise the community spouse's income to, but not more than, the Community Spouse Maintenance Needs Allowance (described in subsection

(f) of this Section).

A) The Department will measure the amount of an allowable increase in the CSAA by the cost to purchase an actuarially sound single premium life annuity producing monthly payments that, when added to the community spouse's income, will be sufficient to raise the community spouse's income to, but not more than, the Community Spouse Maintenance Needs Allowance. If assets are insufficient to purchase such an annuity, the Department will measure the amount of an allowable increase in the CSAA by the cost to purchase an actuarially sound single premium life annuity producing monthly payments using available assets.

B) It is the appellant's responsibility to provide the Department with an estimate from a reputable company of the cost to purchase the annuity.

C) The Department may compare the estimate with available information on the cost of other single premium life annuities.

D) In calculating the amount of the community spouse's income after approval of an increased CSAA, the Department shall deem the amount of the annuity payments as being available to the community spouse, although it will not require the actual purchase of an annuity.

e) The appeal hearing, described in subsection (d)(2) of this Section, shall be held within 30 days after the date the appeal is filed.

f) Deductions are allowed from the MANG client's non-SSI income for a Community Spouse Maintenance Needs Allowance and a Family Maintenance Needs Allowance for each dependent family member who is living with the community spouse and who does not have enough income to meet his or her needs. Family members include dependent children under age 21, dependent adult children, dependent parents or dependent siblings of either spouse. The amount of the deduction is determined as follows:

1) The deduction for the Community Spouse Maintenance Needs Allowance, as of October 1, 1989, is equal to the community spouse maintenance needs standard ($1,500) less any nonexempt monthly income of the community spouse. The amount established as the community spouse maintenance needs standard shall be provided for calendar years after 1989 by the Department of Health and Human Services. The deduction is allowed only to the extent the income of the individual is contributed to the community spouse. However, the deduction for the Community Spouse Maintenance Needs Allowance shall not be less than the amount ordered by the court for support of the community spouse or the amount determined as the result of the fair hearing.

2) The deduction for the Family Maintenance Needs Allowance for each dependent family member is equal to one-third of the difference between the family maintenance needs standard (122% of the Federal Poverty Level for two persons as of September 30, 1989, 133% as of July 1, 1991 and 150% as

of July 1, 1992) and any nonexempt income of the family member.

(Source: Amended at 21 Ill. Reg. 7748, effective June 9, 1997)

Section 120.380 Assets

a) The value of nonexempt assets shall be considered in determining eligibility for AABD MANG. Assets do not affect eligibility for TANF MANG.

b) Jointly held assets for AABD MANG shall be treated in the same manner as described in 89 Ill. Adm. Code 113.140.

c) Potential payments from a Medicaid qualifying trust for AABD MANG and MANG(C) shall be treated in the same manner as described in Section 120.346.

d) Trusts established on or after August 11, 1993, shall be treated in the manner described in Section 120.347.

e) The value of a life estate shall be determined at the time the life estate in the property is established and at the time the property (for example, assets) is liquidated. In determining the value of a life estate and remainder interest based on the value of the property at the time the life estate is established or of the amount received when the property is liquidated, the Department shall apply the values described in Section 120.Table A. The life estate and remainder interest are based on the age of the person at the time the life estate in the property is established and at the time the property is liquidated and the corresponding values described in Section 120.Table A.

(Source: Amended at 22 Ill. Reg. 19875, effective October 30, 1998)

Section 120.381 Exempt Assets

AABD MANG-assets exempt from consideration for AABD MANG shall be as follows:

a) The following assets are exempt from consideration in determining eligibility for assistance and the amount of the assistance payment:
   1) Homestead property
   2) Personal Property
      A) Personal effects and household goods of reasonable value (reasonable value means the client's equity value in such property does not exceed $2,000). Wedding and engagement rings and items required due to medical or physical condition.
      B) Regardless of the value, personal effects and household goods are exempt in determining the amount allowed as the Community Spouse Asset Allowance (as described in Section 120.386).
   3) Resources (for example, land, buildings, equipment and supplies or tools) necessary for self-support up to $6,000 of the individual's equity in the income producing property, provided the property produces a net annual income of at least six percent of the excluded equity value of the property. The equity value in excess of $6,000 is applied toward the asset disregard. If the activity produces income that is less than six percent of the exempt equity due to reasons beyond the individual's control (for example, the individual's illness or crop failure) and there is a reasonable expectation that the individual's activity will increase to produce income equal to six percent of the equity value (for example, a medical prognosis that the individual is expected to respond to treatment or that drought resistant corn will be planted), the property is exempt. If the individual owns more than one piece of property and each produces income, each is looked at to determine if the six percent rule is met and then the amounts of the individual's equity in all of those properties are totaled to see if the total equity is $6,000 or less.
   4) Automobile
      A) Exclude one automobile, regardless of value, used by the client, spouse, or other dependent if:
         i) it is necessary for employment;
         ii) it is necessary for the medical treatment of a specific or regular medical problem;
         iii) it is modified for operation by, or transportation of, a handicapped person;
         iv) it is necessary because of factors such as climate, terrain or distance to provide necessary transportation to perform essential daily activities; or
         v) one vehicle for each spouse is exempt in determining the amount allowed as the Community Spouse Asset Allowance (as described in Section 120.386).

B) If not excluded in subsection (a)(4)(A) of this Section, exclude one automobile to the extent the fair market value does not exceed $4500. Apply the excess fair market value toward the asset disregard (see 89 Ill. Adm. Code 113.142). The Department will determine fair market value in accordance with 89 Ill. Adm. Code 121.57(b)(2)(D)(iv).

C) For all other automobiles, apply the equity value (fair market value minus any encumbrance) toward the asset disregard (see 89 Ill. Adm. Code 113.142).

5) Life insurance policies with a total face value of $1,500 or less and all term life insurance policies. If the total face value exceeds $1,500, the cash surrender value must be counted as a resource.

b) Burial spaces and funds are exempt as follows:

1) Burial spaces which are intended for the use of the individual, his or her spouse, or any other member of his or her immediate family. Immediate family is defined as an individual's minor and adult children, including adopted children and step-children, an individual's brothers, sisters, parents, adoptive parents, and the spouses of these individuals.

2) Funds set aside for the burial expenses of the individual and his or her spouse, subject to a limit of $1,500 each. This limit will be reduced by the face value of any excluded life insurance policy and the amount of any funds held in an irrevocable trust or other irrevocable arrangement which is available for burial expenses.

3) Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements which occurred the earlier of the date of first SSI eligibility or the date of AABD eligibility, but no earlier than November 1, 1982 (see 20 CFR 416.1231(b)(5)(1992)).

4) Funds specifically and irrevocably set aside for the professional funeral services and burial expenses of the individual and his or her spouse, subject to a limit of $4,000 each, including prepaid funeral and burial plans. This limit will be increased annually by three percent.

c) Assets necessary for fulfillment of an approved plan for achieving self support.

d) Trust funds are exempt as follows:

1) The principal of a trust fund only when the instrument establishing the trust specifically states the principal cannot be impaired.

2) The principal of a trust fund established under the Self Sufficiency Trust Fund Program [20 ILCS 1705/21.1].

e) Assets excluded by express provision of 20 CFR 416.1236 (1997).

f) Donations or benefits from fund raisers held for a seriously ill client provided the client or a responsible relative of the client does not have control (for example, not available to the client or the responsible relative) over the donations or benefits or the disbursement of donations or benefits.

g) Payments made to veterans who receive an annual disability payment or to the survivors of deceased veterans who receive a one time lump sum payment from the

Agent Orange Settlement Fund or any other fund referencing Agent Orange product liability under Public Law 101-201.

h) Money received from the Social Security Administration under a Plan to Achieve Self-Support (PASS) and held in a separate account.

i) Disaster relief payments provided by federal, State or local government or a disaster assistance organization.

j) The amount of earned income tax credit which the client receives as advance payment or as a refund of federal income tax.

(Source: Amended at 23 Ill. Reg. 2381, effective January 22, 1999)

Section 120.382 Asset Disregard

In addition to the exempt assets listed in Section 120.381, the cash value of assets shall be disregarded for AABD MANG as follows:

a) $2,000 for a client and $3,000 for a client and one dependent residing together.

b) $50 for each additional dependent residing in the same household.

c) The amount equal to the sum of qualifying insurance benefit payments made as a result of coverage under a Long Term Care Partnership Insurance Policy, as described in 50 Ill. Adm. Code 2018, provided that the person has received all of the qualifying insurance benefit payments that are payable under the policy.

d) All assets of a person who purchases a Long Term Care Partnership Insurance Policy, as described in 50 Ill. Adm. Code 2018, with coverage equal to the average cost of four years of long term care services in a nursing facility, provided that the person has received all of the qualifying insurance benefit payments that are payable under the policy.

e) Eligibility for AABD MANG does not exist when nonexempt assets exceed the above disregard.

f) Qualified Medicare Beneficiary (QMB)

    1) $4,000 for a single person and $6,000 for a person with one or more dependents.

    2) Eligibility for QMB status does not exist when countable assets exceed the above disregard.

(Source: Amended at 22 Ill. Reg. 19875, effective October 30, 1998)

Section 120.383 Deferral of Consideration of Assets

a) Consideration of excess assets may be deferred for a period not to exceed two months for applicants who are leaving a State School or State mental hospital to enter group care facilities and for whom the exact trust fund amount cannot be determined but appears not to exceed one month's needs.

b) A final decision concerning use or disposal of nonexempt assets may be deferred for 90 days, from the date assistance is initially authorized, when it can be assumed at the time of application that the period of eligibility will not extend beyond 90 days.

(Source: Amended at 22 Ill. Reg. 19875, effective October 30, 1998)

Section 120.384 Spend-down of Assets (AABD MANG)

a) Determination of Assets

1) For individuals residing in the community the Department determines the amount of non-exempt assets using the verified amount on the date of decision on the application for medical assistance. The date of verification may be prior to the date of decision. Money considered as income for a month is not considered as an asset for that same month. If income for a month is added to a bank account that month, the Department will subtract the amount of income from the bank balance to determine the asset level. Any income remaining the following month(s) is considered as an asset.

2) The amount of non-exempt assets verified during the application process is used on the date of decision. If medical eligibility includes a backdated month(s), for the backdated month(s), the Department will consider the amount of assets available to apply to the cost of medical care. The Department will not determine the value of assets for a backdated month(s) of eligibility. However, the amount of the excess assets verified during the application process is used to determine spend-down status in each backdated month of eligibility.

3) Once the excess asset has been used to meet spend-down, whether or not the excess amount has actually been reduced, it is no longer considered. However, at reapplication/ redetermination, the Department will consider any excess non-exempt assets remaining as currently available.

b) Community Cases (AABD MANG)

For AABD MANG, to determine the spenddown obligation for clients in the community, the Department will compare monthly countable income to the appropriate MANG standard and add any non-exempt assets in excess of the appropriate asset disregard to non-exempt monthly income in excess of the appropriate MANG Standard.

1) Regular AABD MANG - Community Residents

When an individual residing in the community, has countable monthly income of not more than 99 cents over the appropriate MANG Standard and has non-exempt excess assets of not more than 99 cents over the appropriate asset disregard, the case is referred to as a Regular MANG case. Payment for covered services is made for each month eligibility exists.

2) Spend-down AABD MANG

A) When an individual resides in the community and has countable monthly income of at least $1.00 over the MANG Standard and/or non-exempt assets of at least $1.00 in excess of the asset disregard for the appropriate size household, the case is referred to as a community spend-down case. The spend-down amount is the sum of the amount of income in excess of the MANG Standard plus non-exempt assets in excess of the appropriate asset disregard. The Department will

disregard any excess income and/or asset amounts that are not at least $1.00 over the appropriate standard or disregard.

B) If the individual presents verification that the excess amount is no longer available, the Department will make the appropriate changes the month following the month the assets were transferred.

C) Individuals enrolled in spend-down are not eligible for payment of covered medical services until spend-down is met. Spend-down is met by presenting allowable medical bills or receipts to the Department that equal the amount of the individual's excess countable income and/or non-exempt excess assets. Excess assets do not have to be reduced prior to the authorization of medical assistance.

c) Group Care Cases

To determine the spend-down obligation for AABD MANG clients in group care, the Department will compare monthly countable income and non-exempt assets in excess of the appropriate asset disregard to the cost of long term care at the private pay rate or the Department rate, whichever is greater. When an individual has non-exempt excess assets, the excess amount is applied to the monthly long term care charges after the monthly countable income has been applied.

1) Regular Group Care

When an individual in group care has countable monthly income plus non-exempt assets in excess of the applicable asset disregard of not more than 99 cents over the private pay rate or the Department rate, whichever is greater, the case is referred to as a Regular Group Care case. If monthly countable income plus excess non-exempt assets are less than the long term care charges at the Department rate, the Department will pay the difference.

2) Group Care Spend-down

A) When an individual in group care has countable monthly income plus non-exempt assets in excess of the applicable asset disregard of at least $1.00 over the cost of long term care at the private pay rate or the Department rate, whichever is greater, the case is referred to as a Group Care Spend-down case. The spend-down amount is the sum of the monthly countable income plus non-exempt assets over the applicable asset disregard.

B) The transfer of asset policy set forth in Section 120.385 still applies. Once the client has been determined to have a resource spend-down because of excess non-exempt assets, the spend-down cannot be eliminated by a non-allowable transfer made to qualify for or increase the need for medical assistance.

C) If the individual presents verification that the excess amount is no longer available and the transfer of assets is allowable according to Section 120.385, the Department will make the appropriate changes the month following the month the assets were transferred. If spend-down has been met, the policy set forth in Section 120.385 regarding

transfer of assets does not apply. The client may dispose of the asset as he/she wishes as it has been applied to a met spend-down.

D) Individuals enrolled in spend-down are not eligible for payment of covered medical services until spend-down is met. Spend-down is met by presenting allowable medical bills or receipts to the Department that equal the amount of the individual's excess countable income and/or non-exempt assets. Excess assets do not have to be reduced prior to the authorization of medical assistance.

(Source: Amended at 22 Ill. Reg. 19875, effective October 30, 1998)

Section 120.385 Property Transfers for Applications Filed Prior to October 1, 1989 (Repealed)

(Source: Repealed at 17 Ill. Reg. 1102, effective January 15, 1993)

Section 120.386 Property Transfers Occurring On or Before August 10, 1993

a) Applicability
   1) The provisions for the transfer of property (for example, assets) in this Section only apply to institutionalized persons when the transfer occurs on or before August 10, 1993. An institutionalized person is defined as a resident of a long term care facility, including a resident who was living in the community at the time of the transfer, and to individuals who but for the provision of home and community-based services under Section 4.02 of the Illinois Act on the Aging would require the level of care in a long term care facility. An institutionalized person also includes an individual receiving home and community-based services under Section 4.02 of the Illinois Act on the Aging who was not receiving these services at the time of the transfer.
   2) Transfers of property disregarded as a result of payments made by a Long Term Care Partnership Insurance Policy (as described in 50 Ill. Adm. Code 2018) are not subject to the provisions of subsections (b), (c), and (d) of this Section.
   3) The provisions for the transfer of property (for example, assets) in this Section apply to the transfer of property by the institutionalized person's spouse in the same manner as if the institutionalized person transferred the property.

b) A transfer of assets occurs when an institutionalized person or an institutionalized person's spouse buys, sells or gives away real or personal property or changes (for example, change from joint tenancy to tenancy in common) the way property is held. Changing ownership of property to a life estate interest is an asset transfer (the value of the life estate and remainder interest is determined as described in Section 120.380 and 89 Ill. Adm. Code 113.140). A transfer occurs when an action or actions are taken which would cause an asset or assets not to be received (for example, waiving the right to receive an inheritance).

c) A transfer is allowable if:
   1) the transfer occurred more than 30 months before the date of application or more than 30 months before entry into the long term care facility or more than 30 months before receipt of services provided by the Illinois Department on Aging under the In-Home Care Program (as described in Section 140.643);
   2) a fair market value was received. Fair market value is the price that an article or piece of property might be expected to bring if offered for sale in a fair market. Fair market value is determined by statements obtained from institutions, community members, etc. (for example, bankers, jewelers, reputable realtors, etc.) recognized as having knowledge of property values;
   3) homestead property was transferred to:
      A) a spouse;
      B) the individual's child who is under age 21;

C) the individual's child who is blind or permanently and totally disabled;

D) the individual's brother or sister who has an equity interest in the homestead property and who was residing in the home for at least one year immediately prior to the date the individual became institutionalized; or

E) the individual's child who provided care for the individual and who was residing in the homestead property for two years immediately prior to the date the individual became institutionalized;

4) the transfer by the institutionalized person was to the community spouse or to another individual for the sole benefit of the community spouse and the amount transferred does not exceed the Community Spouse Asset Allowance (as described in Section 120.379);

5) the transfer was to the individual's child who is blind or permanently and totally disabled or to another person for the sole benefit of the individual's child;

6) the individual intended to transfer the assets for fair market value;

7) it is determined that denial of assistance would create an undue hardship. Examples of undue hardship include, but are not limited to, situations in which:

A) the individual is mentally unable to explain how the assets were transferred;

B) the denial of assistance would force the resident to move from the long term care facility; or

C) the individual would be prohibited from joining a spouse in a facility or would prohibit the individual from entering a facility that is within close proximity to his/her family;

8) the transfer was made exclusively for a reason other than to qualify for assistance. A transfer for less than fair market value is presumed to have been made to qualify for assistance unless a satisfactory showing is made to the Department that the client or spouse transferred the asset exclusively for a reason other than to qualify for assistance;

9) the transfer by the individual was to the community spouse and was the result of a court order; or

10) the transfer was to an annuity and the expected return on the annuity is commensurate with the estimated life expectancy of the person. In determining the estimated life expectancy of the person, the Department shall use the life expectancy table described in Section 120.Table B.

d) If a transfer or transfers do not meet the provisions of subsection (c), the client is subject to a period of ineligibility for long term care services and for services provided by the Illinois Department on Aging under the In-Home Care Program (as described in Section 140.643). The penalty period is determined in accordance with subsection (e). If otherwise eligible, clients remain entitled to other covered medical

services.

e) A separate penalty period is determined for each month in which a transfer or transfers do not meet the provisions of subsection (c). Each penalty period is the lesser of the number of months the total uncompensated amount of the transferred assets would meet the monthly cost of long term care at the private rate or 30 months.

f) The penalty period begins with the month of the transfer or transfers unless the transfer or transfers occurred during a previous penalty period. If so, the penalty period begins with the month following the month the previous penalty period ends. However, the penalty period cannot exceed 30 months from the month of the transfer or transfers.

(Source: Amended at 19 Ill. Reg. 15079, effective October 17, 1995)

Section 120.387 Property Transfers Occurring On or After August 11, 1993

a) The provisions for the transfer of property (for example, assets) listed below only apply to institutionalized persons when the transfer occurs on or after August 11, 1993. An institutionalized person is defined as a resident of a long term care facility, including a resident who was living in the community at the time of the transfer, and to individuals who but for the provisions of home and community-based services under Section 4.02 of the Illinois Act on the Aging would require the level of care, in a long term care facility. An institutionalized person also includes an individual receiving home and community-based services under Section 4.02 of the Illinois Act on the Aging who was not receiving these services at the time of the transfer.

b) The provisions for the transfer of property (for example, assets) listed below apply to the transfer of property by the institutionalized person's spouse in the same manner as if the institutionalized person transferred the property.

c) Transfers of property disregarded as a result of payments made by a Long Term Care Partnership Insurance Policy (as described in 50 Ill. Adm. Code 2018) are not subject to the provisions of this Section.

d) A transfer of assets occurs when an institutionalized person or an institutionalized person's spouse buys, sells or gives away real or personal property or changes (for example, change from joint tenancy to tenancy in common) the way property is held. Changing ownership of property to a life estate interest is an asset transfer (the value of the life estate and remainder interest is determined as described at Section 120.380 and 89 Ill. Adm. Code 113.140). For assets held in joint tenancy, tenancy in common or similar arrangement, a transfer occurs when an action by any person reduces or eliminates the person's ownership or control of the asset. A transfer occurs when an action or actions are taken which would cause an asset or assets not to be received (for example, waiving the right to receive an inheritance).

e) A transfer is allowable if:

1) depending on the property transferred, the transfer occurred more than either 60 or 36 months before the date of application, or more than either 60 or 36 months before entry into a long term care facility or more than either 60 or 36 months before receipt of services provided by the Illinois Department on Aging under the In-Home Care Program (as described in Section 140.643);

A) the 60 month period applies to payments from a revocable trust that are not treated as income (as described in Section 120.347) and to portions of an irrevocable trust from which no payments could be made (as described in Section 120.347);

B) the 36 month period applies to payments from an irrevocable trust that are not treated as income (as described in Section 120.347) and to any other property transfers not identified in this subsection;

2) a fair market value was received. Fair market value is the price that an article or piece of property might be expected to bring if offered for sale in a fair market. Fair market value is determined by statements obtained from

institutions, community members, etc. (for example, bankers, jewelers, reputable realtors, etc.) recognized as having knowledge of property values;

3) homestead property was transferred to:
   A) a spouse;
   B) the person's child who is under age 21;
   C) the person's child who is blind (as described in Section 120.313) or disabled (as described in Section 120.314);
   D) the person's brother or sister who has an equity interest in the homestead property and who was residing in the home for at least one year immediately prior to the date the person became institutionalized; or
   E) the person's child who provided care for the person and who was residing in the homestead property for two years immediately prior to the date the person became institutionalized;
4) the transfer by the institutionalized person was to the community spouse or to another person for the sole benefit of the community spouse and the amount transferred does not exceed the Community Spouse Asset Allowance (as described in Section 120.379);
5) the transfer from the community spouse was to another person for the sole benefit of the community spouse;
6) the transfer was to the person's child or to a trust established solely for the benefit of the person's child who is blind (as described in Section 120.313) or disabled (as described in Section 120.314) or to another person for the sole benefit of the person's child;
7) the transfer was to a trust established solely for the benefit of a person under age 65 who is disabled (as described in Section 120.314);
8) the person intended to transfer the assets for fair market value;
9) it is determined that denial of assistance would create an undue hardship. Examples of undue hardship include, but are not limited to, situations in which:
   A) the individual is mentally unable to explain how the assets were transferred;
   B) the denial of assistance would force the resident to move from the long term care facility; or
   C) the individual would be prohibited from joining a spouse in a facility or would prohibit the individual from entering a facility that is within close proximity to his or her family;
10) the transfer was made exclusively for a reason other than to qualify for assistance. A transfer for less than fair market value is presumed to have been made to qualify for assistance unless a satisfactory showing is made to the Department that the client or spouse transferred the asset exclusively for a reason other than to qualify for assistance;
11) the transfer by the client was to the community spouse and was the result of a

court order;

12) the assets transferred for less than fair market value have been returned to the person; or

13) the transfer was to an annuity, the expected return on the annuity is commensurate with the estimated life expectancy of the person, and the annuity pays benefits in approximately equal periodic payments. In determining the estimated life expectancy of the person, the Department shall use the life expectancy table described in Section 120.Table B.

f) If a transfer or transfers do not meet the provisions of subsection (e), the client is subject to a period of ineligibility for long term care services and for services provided by the Illinois Department on Aging under the In-Home Care Program (as described in Section 140.643). The penalty period is determined in accordance with subsection (g) of this Section. If otherwise eligible, clients remain entitled to other covered medical services.

g) A separate penalty period is determined for each month in which a transfer or transfers do not meet the provisions of subsection (e) of this Section. Each penalty period is the number of months equal to the total uncompensated amount of assets transferred during a month divided by the monthly cost of long term care at the private rate.

h) The penalty period begins with the month of the transfer or transfers unless the transfer or transfers occurred during a previous penalty period. If so, the penalty period begins with the month following the month the previous penalty period ends.

i) For transfers by the community spouse that result in a penalty period as described in subsection (g) of this Section and the community spouse becomes an institutionalized person and is otherwise eligible for assistance, the Department shall divide any remaining penalty period equally between the spouses.

(Source: Amended at 23 Ill. Reg. 11301, effective August 27, 1999)

Section 120.390 Persons Who May Be Included In the Assistance Unit

a) MANG(C)

1) The assistance unit must include at least one eligible child or only an adult(s) caretaker relative whose eligibility is based on a child who is otherwise eligible except the child receives SSI. No more than two of the following individuals may be included as adults:

A) The caretaker relative;

B) The parent of an eligible child;

C) The needy relative other than the caretaker relative who provides at least one of the following services:

i) child care which enables the caretaker relative to work on a full-time (at least 100 hours per month) paid basis outside the home;

ii) care for an incapacitated family member in the home;

iii) child care that enables a caretaker relative to receive training full-time;

iv) child care that enables a caretaker relative to attend high school or General Educational Development (GED) classes full-time; or

v) child care for a period not to exceed two months that enables the caretaker relative to participate in a Project Chance (AFDC) work program such as Job Search.

2) The eligibility of a child in an Assistance unit depends on that child's lack of parental support or care. All eligible dependent children and stepchildren in a family unit shall be included in a single case, except in two-parent households where there are children of differing parentage, some of whom lack parental support or care because of the unemployment of a parent. In such a circumstance two separate assistance cases shall be established: one for both adults and children whose eligibility derives from their parent's unemployment and one for the remaining children. The provisions of this Section shall not affect the right of a child who is a parent to receive assistance in a separate case as a caretaker relative for his/her dependent child.

b) MANG(AABD)

The eligible person only shall be included in the assistance unit.

c) MANG(P)

The assistance unit shall only include pregnant women and children born October 1, 1983, or later who meet the eligibility requirements of Section 120.11.

(Source: Amended at 16 Ill. Reg. 11582, effective July 15, 1992)

Section 120.391 Individuals Under Age 18 Who Do Not Qualify For AFDC/AFDC-MANG And Children Born October 1, 1983, or Later

a) Individuals Under Age 18

1) Medical assistance shall be provided to individuals under age eighteen (18) who do not qualify for AFDC under the definition of dependent child as defined in 89 Ill. Adm. Code 101.20 and 112.61 through 112.64. However, such individuals must meet the eligibility requirements and other provisions of 89 Ill. Adm. Code 112.10, 112.20, and 112.Subpart C.

2) If non-exempt countable income (see Sections 120.360 thru 120.375) is equal to or less than the appropriate MANG (AFDC) standard, (see Section 120.30) the individual is eligible for payment of his/her allowable medical care costs (see 89 Ill. Adm. Code 140.3).

3) Persons whose income exceeds the appropriate MANG (AFDC) standard are eligible for medical assistance each month incurred or paid medical care costs equal the amount of excess non-exempt income over the standard. When income exceeds the MANG (AFDC) standard, eligibility begins on the day in the month incurred or paid medical care costs equals excess monthly income. Eligibility ends on the last day of the same month.

b) Children Born October 1, 1983, or Later

Medical assistance shall be provided to children born October 1, 1983, or later who do not qualify as mandatory categorically needy (Social Security Act (42 U.S.C. 1902(a)(10)(A)(i) and 1905(n)) and meet the eligibility requirements of 89 Ill. Adm. Code 120.11, 120.31, 120.64.

(Source: Amended at 16 Ill. Reg. 11582, effective July 15, 1992)

Section 120.392 Pregnant Women Who Would Not Be Eligible For AFDC/AFDC-MANG If The Child Were Already Born Or Who Do Not Qualify As Mandatory Categorically Needy

a) Pregnant women who would not be eligible for AFDC/AFDC-MANG if the child were already born
   1) Medical assistance shall be provided to women of any age who are pregnant and meet the asset standards (see Sections 120.380 thru 120.382) of the AFDC medical assistance program and who would not be eligible for AFDC if the child were already born because:
      A) the father is not absent, and
      B) neither parent is incapacitated (see 89 Ill. Adm. Code 112.62) and the principal wage earner does not meet the Department's definition of unemployment (see 89 Ill. Adm. Code 112.64).
   2) Medical assistance for up to sixty (60) days following the last day of pregnancy.
      A) Medical assistance shall be provided for the woman and newborn child for up to sixty (60) days following the last day of the pregnancy. The sixty (60) day medical coverage continues through the last day of the calendar month in which the sixty (60) day period ends.
      B) In order for a pregnant woman to qualify for the extended sixty (60) day medical coverage, an AFDC MANG application must have been filed prior to the date the pregnancy ended.

b) Pregnant women who do not qualify as mandatory categorically needy
   1) Medical assistance shall be provided to women of any age who do not qualify as mandatory categorically needy (Sections 1902(e)(10)(A)(i) and 1905(n) of the Social Security Act) and meet the eligibility requirements of Sections 120.11, 120.31 and 120.64).
   2) Medical assistance shall be provided for the woman and newborn child(ren) for up to sixty (60) days following the last day of the pregnancy. The sixty (60) day medical coverage continues through the last day of the calendar month in which the sixty (60) day period ends.

(Source: Amended at 12 Ill. Reg. 19704, effective November 15, 1988)

Section 120.393 Pregnant Women And Children Under Age Eight Years Who Do Not Qualify As Mandatory Categorically Needy Demonstration Project

The Department shall conduct a six-month demonstration project in Macon County and the Garfield and Western local offices of Cook County to test the impact of providing Medicaid to pregnant women and children under age eight years who do not qualify as mandatory categorically needy and whose incomes are no more than 185 percent of the Federal Poverty Income Guidelines.

(Source: Added at 13 Ill. Reg. 15404, effective October 6, 1989)

Section 120.395 Payment Levels for MANG (Repealed)

(Source: Repealed at 20 Ill. Reg. 15993, effective December 9, 1996)

Section 120.399 Redetermination of Eligibility

It is the Department's responsibility to determine the continued eligibility of all recipients of medical assistance and it is the recipient's responsibility to cooperate in the redetermination of eligibility. A redetermination of eligibility shall be conducted at least every twelve six months and at any time it becomes known to the Department that a recipient's circumstances affecting eligibility may have changed.

(Source: Amended at 25 Ill. Reg. 16098, effective December 1, 2001)

Section 120.400 Twelve Month Eligibility for Persons under Age 19

a) Coverage under the Department's Medical Assistance Program shall be provided for all eligible persons under 19 years of age for a 12 month period, regardless of any changes in income that may occur during that period, except as provided in subsections (c) and (d) of this Section. Provisions under this Section are not applicable to persons under age 19 who do not experience any changes in circumstances and continue to meet all medical assistance eligibility requirements.

b) The 12 month period shall begin the later of:
   1) the month in which initial eligibility is determined; or
   2) the month in which eligibility has most recently been determined.

c) Eligibility shall end when the earliest of the following occurs:
   1) the 12 month period ends; or
   2) the person attains age 19; or
   3) the person is no longer a resident of Illinois; or
   4) the person is incarcerated; or
   5) the person dies; or
   6) the Department determines that, at the time of application, incorrect or inaccurate information was provided that affected the eligibility determination; or
   7) the caretaker relative requests termination; or
   8) the child is also the caretaker relative of a child receiving benefits under the Public Aid Code and fails to cooperate with the support enforcement for that child as required by 89 Ill. Adm. Code 160.30; or
   1) the Department determines that the child was incorrectly determined to be eligible.

d) Twelve month eligibility under this Section shall not apply to any person who:
   1) has only been determined to be presumptively eligible;
   2) has a spenddown; or
   3) has only been determined eligible for emergency medical assistance under Section 120.310(b)(3).

(Source: Added at 24 Ill. Reg. 7361, effective May 1, 2000)

SUBPART I: SPECIAL PROGRAMS

Section 120.500 Health Benefits for Persons with Breast or Cervical Cancer

a) A person shall be eligible for medical assistance if the person meets the following eligibility requirements under Health Benefits for Persons with Breast or Cervical Cancer (BCC):
   1) Cooperate in establishing eligibility as described in Section 120.308.
   2) Meet citizenship/immigration status as described in Section 120.310.
   3) Meet residency requirements as described in Section 120.311.
   4) Assign rights to medical support and collection of payment as described in Section 120.319.
   5) Furnish a Social Security number as described in Section 120.327.
   6) Be under the age of 65 years.
   7) Have been screened for breast or cervical cancer under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) administered by the Illinois Department of Public Health (IDPH) as described in subsection (c) of this Section, and have been found to need treatment, as defined in subsection (d) of this Section, for breast or cervical cancer or a precancerous condition as defined in subsection (e) of this Section.
   8) Continue to need treatment as defined in subsection (d) of this Section.
   9) Be uninsured, that is, must not have creditable coverage, as defined under the Health Insurance Portability and Accountability Act, for breast or cervical cancer treatment.

b) A person shall not be determined eligible for Health Benefits for Persons with Breast or Cervical Cancer:
   1) if the person is otherwise eligible for medical assistance under Section 120.11, 120.20 or 120.30 without a spenddown; or
   2) if the person is in a correctional facility pursuant to 42 CFR 435.1008.

c) A person shall meet the screening requirement if the person's breast or cervical cancer screening was within the scope of a grant, sub-grant or contract under the NBCCEDP administered by IDPH.

d) A person shall be considered to need treatment if, in the opinion of the person's treating physician, the person requires therapy directed toward cure or palliation of breast or cervical cancer, including recurrent metastatic cancer that is a known or presumed complication of breast or cervical cancer and complications resulting from the treatment modalities themselves. Treatment includes diagnostic services that may be necessary to determine the extent and proper course of treatment. Persons who require only routine monitoring services (for example, pap smears or mammograms) are not considered to need treatment.

e) For the purposes of this Section, a precancerous condition means:
   1) Cervical intraepithelial neoplasia, grade III (CIN III);
   2) Severe dysplasia of the cervix;

3) High-grade squamous intraepithelial lesion (HGSIL); or
4) Atypical glandular cells of undetermined significance (AGUS) with a suspicion of adenocarcinoma in situ.

f) All income and assets shall be exempt from consideration in determining eligibility under this Section.

g) A person's eligibility for medical assistance under this Section shall be terminated when the person no longer meets the requirements of this Section.

h) Application Process
1) The process of applying for medical assistance shall be initiated by the submission to the Department, by an entity designated by IDPH, of a statement certifying that a person meets the condition of eligibility described in subsection (a)(7) of this Section.
2) The Department shall contact the person by telephone, mail or other appropriate means to complete an application.
3) The application date shall be the date a signed application is received in the Department's central breast and cervical cancer eligibility unit.
4) Application may be made by additional methods that the Department establishes.
5) Applications shall meet all requirements found at 89 Ill. Adm. Code 110.10(a), (c), (e) and (i).
6) A BCC application is only an application for Health Benefits for Persons with Breast or Cervical Cancer.

i) Authorization of Medical Assistance Eligibility
1) Eligibility will be effective no earlier than the third month before the month of application if the applicant received medical services during that period and would have been eligible if he or she had applied. In no case shall eligibility be effective prior to July 1, 2001.
2) The applicant may choose to receive medical assistance for any of the three months prior to the month of application.
3) Eligibility can begin no earlier than the month in which the applicant was screened as described in subsection (a)(7) of this Section.

j) Persons enrolled in Health Benefits for Persons with Breast or Cervical Cancer shall be exempt from Sections 102.210 and 102.230.

k) Persons enrolled in Health Benefits for Persons with Breast or Cervical Cancer who enter a nursing facility must provide income information sufficient for the Department to calculate a group care credit, as established in Sections 120.40 and 120.60, except that assets shall not be counted. The Department will not pay for nursing facility services for any person who refuses to provide the required information.

l) Persons applying for or enrolled in Health Benefits for Persons with Breast or Cervical Cancer shall be entitled to appeal rights as described at 89 Ill. Adm. Code 102.80.

(Source: Added at 25 Ill. Reg. 409, effective December 28, 2001)

Section 120.510 Health Benefits for Workers with Disabilities

a) To be eligible for medical assistance under Health Benefits for Workers with Disabilities, an individual must meet all of the following eligibility requirements:

1) Cooperate in establishing eligibility as described in Section 120.308.

2) Meet citizenship/immigration status as described in Section 120.310.

3) Meet residency requirements as described in Section 120.311.

4) Be disabled as described in Section 120.314.

5) Assign rights to medical support and collection of payment as described in Section 120.319.

6) Furnish a Social Security number(s) as described in Section 120.327.

7) Be 16 through 64 years of age.

8) Have countable monthly income at or below 200 percent of the Federal Poverty Level.

9) Have non-exempt assets at or below $10,000.

10) Be employed pursuant to subsection(l)(1) of this Section or qualify for an exception as described in subsection (l)(2) of this Section.

11) Pay a premium pursuant to subsections (m) and (n) of this Section.

b) An individual shall not be determined eligible if the individual is otherwise eligible for medical assistance without a spenddown.

c) An individual who is otherwise eligible for medical assistance with a spenddown, who meets the requirements of this Section, shall have the option of enrolling in medical assistance with a spenddown or Health Benefits for Workers with Disabilities.

d) An individual's eligibility shall be terminated if the individual no longer meets the requirements of this Section.

e) Certain assets shall be exempt from consideration in determining eligibility in accordance with Section 120.381.

f) The earned and unearned income of the following persons shall be counted when determining eligibility, except as specified in subsections (g), (h) and (i) of this Section.

1) Income of the individual.

2) Income of the spouse.

3) Unearned income of a dependent child under the age of 18 years who is included in the income standard (see Section 120.20) because it is to the advantage of the individual.

g) Monthly unearned income shall be counted as described in Sections 120.330 through 120.345 and Sections 120.350, 120.355, 120.371 and 120.376.

h) Monthly earned income shall be considered as described in Sections 120.360, 120.361, 120.371, 120.372, 120.373 and 120.375.

i) The Department shall exempt earned income as provided in Section 120.362(a) and (b)(1). In addition, work related expenses that are allowed as deductions for AABD MANG as described in Section 120.370 shall be deducted.

j) Application Process

1) Individuals can apply by completing an application provided by the Department and submitting it to an address specified by the Department.

2) The application must meet all requirements found at 89 Ill. Adm. Code 110.10(a), (c), (e) and (i).

k) Authorization of Medical Assistance Eligibility

1) Medical assistance coverage will not be provided for any month for which eligibility is established unless a premium is paid in accordance with subsections (m) and (n) of this Section.

2) Subject to subsections (k)(2)(A), (B) and (C) of this Section, the applicant may choose to receive medical assistance for months prior to the initial month of prospective eligibility as determined in accordance with subsections (m) and (n) of this Section.

A) Eligibility will be effective no earlier than the third month before the

month of application if the applicant received covered medical services during that period and would have been eligible if he or she had applied for Health Benefits for Workers with Disabilities.

B) Months of backdated coverage selected must be consecutive and must be continuous with the initial month of prospective eligibility.

C) Monthly premiums must be paid for all the months of coverage.

l) Individuals Considered Employed

1) For purposes of this program, an individual shall be considered employed if the individual provides verification that current payment under the Federal Insurance Contributions Act (FICA) or Illinois Municipal Retirement Fund (IMRF) has been made on behalf of the individual.

2) Under the following circumstances, an individual may be enrolled in this program without providing evidence of employment as described in subsection (l)(1) of this Section:

A) Individuals who are not employed at the time of application, but who can verify that they will be employed within 60 days, may be enrolled but will not be considered eligible until they begin employment and pay the appropriate premium in accordance with subsections (m) and (n) of this Section.

B) Individuals who become unable to work for medical reasons after enrollment in this program who wish to remain in the program. Such individuals:

i) Must report to the Department within 30 days after the first day that they were unable to work.

ii) Must provide a physician's written statement that they are unable to work, but that the anticipated date for the return to work is within 90 days after the first day they were unable to work.

iii) Must pay premiums in accordance with subsections (m) and (n) of this Section for the months during which they do not work.

C) Individuals who cease employment for any other reason may

continue to be enrolled for 30 days after the employment ends provided they pay premiums in accordance with subsections (m) and (n) of this Section for the period during which they do not work.

3) Eligibility shall be terminated:

A) If an individual determined to be employed according to subsection (l)(2)(A) of this Section does not provide evidence of employment pursuant to subsection (l)(1) of this Section within 30 days after enrollment.

B) If an individual is unable to work for medical reasons, as described in subsection (l)(2)(B) of this Section, for 90 days or more.

C) If an individual ceases employment for any other reason (subsection (l)(2)(C) of this Section) and does not obtain new employment within 30 days after cessation of employment.

m) Premiums

1) The Department must receive payment of the monthly premium for an applicant's initial prospective month of eligibility before the applicant can be enrolled in this program. If payment of the premium is received by the 20th day of the month, the initial month of prospective eligibility shall begin the first day of the following month. (For example, if the premium payment is received on February 20, coverage shall begin on March 1. If the premium payment is received after February 20, coverage shall begin on April 1.)

2) Premiums for months of backdated coverage must be paid within 90 days after the date of the notice of eligibility approval.

3) Subsequent premiums are due on the last day of the month prior to the month of coverage.

4) If payment of the premium is not received in full by the end of the month following the due date of the premium, coverage will terminate effective the end of the second month following the due date and collection action may be initiated by the Department for the unpaid premiums for months of coverage.

n) Determination of Premium Amount

1) Premiums shall be based upon an individual's combined gross unearned and countable earned income as determined at the point of application or review

or redetermination of eligibility.

2) The Department shall reset a premium prospectively based on verified income.

3) Premium amounts shall be established as set forth in the following monthly premium table.

		Gross Unearned Income				
		$0 to $250	$251 to $500	$501 to $750	$751 to $1000	Over $1000
Countable Earned Income	$0 -$250	----	$19	$38	$56	$ 75
	$250-$500	$ 6	$25	$44	$63	$ 81
	$501-$750	$13	$31	$50	$69	$ 88
	$751-$1000	$19	$38	$56	$75	$ 94
	Over $1000	$25	$44	$63	$81	$100

o) Medicaid Buy-In Program Revolving Fund (see 305 ILCS 5/12-10.6)

1) The Medicaid Buy-In Revolving Fund consists of premiums paid by eligible individuals under this Section.

2) Monies in the Fund may be used to pay costs incurred by the Department for:

A) Administering the Health Benefits for Workers with Disabilities (HBWD) program, including, but not limited to, staff, equipment, travel, outreach activities and other operating costs.

B) Personal assistance services (PAS) provided at an individual's work site. PAS under the HBWD program is limited to individuals who do not already receive PAS, have a need for such services on the basis of a disability as described in Section 120.314, and, except for their income and non-exempt assets, would be eligible for the Community Care Program as described at 89 Ill. Adm. Code 240. The need, amount and duration of PAS will be assessed through a determination of need process.

(Source: Amended at 29 Ill. Reg. 10195, effective June 30, 2005)

SUBPART I: SPECIAL PROGRAMS

Section 120.520 SeniorCare

a) To be eligible for SeniorCare pharmaceutical benefits as set forth at 89 Ill. Adm. Code 140.405, an individual must meet all of the following eligibility requirements:

1) Be a U.S. citizen or qualify as an eligible non-citizen pursuant to Section 120.310.

2) Reside in Illinois.

3) Be 65 years of age or older.

4) Assign rights to medical support and collection of payments as described in Section 120.319.

5) Furnish his or her Social Security Number.

6) Have countable annual income at or below 200 percent of the poverty guidelines published annually by the U.S. Department of Health and Human Services.

b) The earned and unearned income of the applicant and his or her spouse (if the spouse resides with the applicant) shall be counted when determining eligibility, except that the following shall not be counted:

1) cash gifts;

2) child support payments;

3) Circuit Breaker grants;

4) damages awarded from a lawsuit for a physical personal injury or sickness;

5) Energy Assistance payments;

6) federal income tax refunds;

7) IRAs "rolled over" into other retirement accounts;

8) lump sums from inheritances;

9) lump sums from insurance policies;

10) money borrowed against a life insurance policy;

11) reverse mortgage income;

12) stipends from the Foster Parent and Foster Grandparent programs; and

13) Worker's Compensation.

c) Assets shall not be considered.

d) SeniorCare participants shall be exempt from the requirements of 89 Ill. Adm. Code 102.210, Estate Claims, with regard to expenditures made for SeniorCare benefits.

e) An individual who is eligible for medical assistance with a spenddown may participate in SeniorCare.

f) An individual who receives benefits from any of the Medicare Savings programs (QMB, SLIB, or QI) may participate in SeniorCare.

g) Application Process

1) Individuals shall apply by completing and submitting an application as specified by the Illinois Department of Revenue.

2) Spouses may apply on the same application as long as the application contains both signatures.

3) After eligibility is determined by the Illinois Department of Revenue, notice of the outcome shall be sent to the applicant.

4) An individual enrolled in SeniorCare shall receive coverage under his or her own name and unique Recipient Identification Number.

h) Enrollment Periods

1) Enrollment shall be effective no later than one month after the date when the applicant was determined to be eligible for the program.

2) An individual who first enrolls in SeniorCare between July 1 and December 31 of any year shall be enrolled through the end of that State fiscal year. For

example, an individual who first enrolls on December 1, 2002, shall be eligible through June 30, 2003.

3) An individual who first enrolls in SeniorCare between January 1 and June 30 of any year shall be enrolled through the end of that fiscal year plus all of the following fiscal year. For example, an individual who first enrolls on January 1, 2003, shall be eligible through June 30, 2004.

4) Individuals must reapply annually.

5) Subsequent uninterrupted periods of enrollment shall be for 12 months and shall be coincident with the State fiscal year.

i) Authorization of SeniorCare

1) Once an individual has been determined eligible for SeniorCare, a SeniorCare identification card shall be sent to the individual.

2) Upon receipt of the card, the participant shall have the option of receiving a SeniorCare Rebate as established in 89 Ill. Adm. Code 140.405 instead of using the SeniorCare card. Enrollment in the SeniorCare Rebate option shall be effective prospectively for the month following the month in which the individual is approved for SeniorCare Rebate.

j) SeniorCare coverage shall terminate:

1) at the end of a participant's enrollment period unless the participant reapplies timely and is found to continue to be eligible;

2) when a participant no longer resides in Illinois;

3) when a participant becomes an inmate of a public institution as set forth in 42 CFR 435.1008;

4) upon a participant's death; or

5) upon discovery that the initial determination of the participant's eligibility was incorrect.

k) Individuals applying for or enrolled in SeniorCare shall be entitled to appeal rights as described at 89 Ill. Adm. Code 102.80.

(Source: Amended at 27 Ill. Reg. 18609, effective November 26, 2003)

Section 120.530 Home and Community Based Services Waivers for Medically Fragile, Technology Dependent, Disabled Persons Under Age 21

a) The Department shall administer a home and community-based service (HCBS) waiver program as set forth in 305 ILCS 5/5-2(7) and 305 ILCS 5/5-2.05(a) and pursuant to Section 1915 (c) of the Social Security Act (42 USC 1396n(c)) for disabled persons under the age of 21 years who are medically fragile and technology dependent. Individuals under the age of 21 years who require institutionalization solely because of a severe mental or developmental impairment are not eligible to receive services under the waiver.

b) A determination must be made that, except for the provision of in-home care, these individuals would require the level of care provided in a hospital or a facility that is Medicaid certified as an Intermediate Care Facility for the Mentally Retarded and licensed by the Department of Public Health under 77 Ill. Adm. Code 390 as a long-term care facility for persons under 22 years of age (SNF/PED).

c) The Division of Specialized Care for Children (DSCC) shall perform operational functions under the HCBS waiver program pursuant to an interagency agreement with the Department.

d) In addition to being eligible for all of the services set forth in 89 Ill. Adm. Code 140.3, individuals covered under the HCBS waiver are eligible for the following waiver services:

1) Respite care;

2) Environmental modifications;

3) Special medical supplies and equipment;

4) Medically supervised day care;

5) Family and nurse training; and

6) Maintenance counseling.

e) Eligibility is subject to Department review. In order to be eligible for a HCBS waiver, an individual must meet all of the following criteria:

l) The individual is under 21 years of age and has been determined to be disabled as defined in Section 120.314; and

2) A medical needs assessment has been performed by an attending physician and the attending physician has determined that, without home and community-based services, the individual would require the level of care provided by a hospital or SNF/PED and that such level of care can be provided safely in the home and community through the provision of medical support services referenced in subsection (d) of this Section; and

3) The estimated cost to the State for in-home care, as compared to the institutional level of care appropriate to the individual's medical needs (hospital or SNF/PED), cannot exceed:

A) if the appropriate comparable institutional level of care for a ventilator dependent individual is a hospital, the greater of:

i) 125 percent of the Statewide average per diem expenditurefor hospital care for the previous fiscal year; or

ii) 100 percent of the average per diem expenditure provided in the hospital from which the individual was placed; or

B) if the appropriate comparable institutional level of care for a non-ventilator dependent individual is a hospital, 125% of the Statewide average per diem expenditure for hospital care in the previous fiscal year; or

C) if the appropriate comparable institutional level of care for the individual is a SNF/PED:

i) the per diem rate of the geographically closest SNF/PED meeting the individual's medical needs; or

ii) if the individual requires exceptional care services pursuant to 89 Ill. Adm. Code 144.100, an exceptional care rate based on the individual's medical needs; and

4) The individual would be eligible for Medicaid if his or her responsible relative's income and resources were excluded from consideration; and

5) A written plan of care has been developed and approved pursuant to subsection (f) of this Section.

f) Plan of Care

1) The Department shall review and approve the level of home and community-based services based on a written plan of care developed by the individual's attending physician, family or guardian and DSCC.

2) At a minimum, the plan of care must describe the medical and other services to be furnished, the frequency of the services, the type of provider required to render the service and a description of the family's or guardian's active participation as care givers in meeting the individual's medical needs.

3) The Department has the authority to approve a cost-effective alternative to services in the plan of care, as long as the alternative services meet the medical needs of the individual.

4) When determining the hours of nursing care necessary to maintain the individual at home, consideration shall be given to the availability of other services, including direct care provided by the individual's family or guardian, that can reasonably be expected to meet the medical needs of the individual.

5) During the first 18 months of participation in the waiver, the Department will review and approve the individual's plan of care every six months. After the first 18 months, the Department will review the plan of care every six months and, depending upon the individual's medical condition, may approve the plan of care for a period not to exceed 12 months.

6) Based on the results of the Department's review, a new plan of care may be developed if warranted by a change in the individual's need for medical services or a change in the individual's home environment.

g) Failure of a family or guardian to cooperate with the Department, DSCC, or service providers in implementing a plan of care may result in termination of benefits under the HCBS waiver if the Department determines that, as a result of such non-cooperation, a plan of care cannot be implemented and the health and well-being of the individual could be jeopardized.

(Source: Added at 28 Ill. Reg. 13760, effective October 1, 2004)

Section 120.540 Illinois Healthy Women Program

a) A woman shall be eligible for medical services under this program if the woman:

1) Meets required citizenship/immigration status as described in Section 120.310;

2) Meets residency requirements as described in Section 120.311;

3) Does not reside in a public institution as described in Section 120.318;

4) Furnishes a Social Security Number as described in Section 120.327;

5) Is 19 through 44 years of age;

6) Did not lose medical assistance without spend-down coverage for refusing to assign rights to medical support and collection of payment, as described in Section 120.319, while receiving medical benefits;

7) Did not lose medical assistance without spend-down coverage for refusing to cooperate in establishing paternity and obtaining medical support rights, as described in Section 120.320, while receiving medical benefits, unless the woman had good cause as described in Section 120.321; and

8) Lost eligibility for medical assistance without a spend-down or a KidCare Health Plan under 89 Ill. Adm. Code 125 for a reason other than as described in subsections (a)(1) through (7) of this Section.

b) Initial coverage will occur automatically beginning on the first day of the month following the last month of Medicaid without spend-down coverage and will continue for three months.

c) If, in the prescribed timeframe of three months for initial coverage, the woman signs and returns the enrollment form that is mailed to her by the Department, eligibility will continue for an additional nine months beginning on the first day of the month that follows the third month of initial coverage.

d) Eligibility must be redetermined once every 12 months. If the woman continues to meet the requirements set forth in subsections (a)(1) through (5) of this Section and her total countable family income is at or below 200 percent of the Federal Poverty Level, the woman will remain eligible for an additional 12 months if, within the prescribed timeframe, she signs and returns the re-enrollment form that is mailed to her.

e) A re-enrollment form will not be mailed to the women if, after coverage under this program began:

1) She reached the age of 45 years;

2) She moved out of Illinois;

3) She became eligible for another medical program under this Part;

4) She became an inmate of a correctional facility or a resident of a public institution;

5) She requested that benefits be terminated; or

6) The Department paid for a sterilization procedure for her.

f) Coverage for all participants shall end upon termination of the federal waiver under which this coverage is provided.

g) Benefits available under this program are those set forth in 89 Ill. Adm. Code 140.486.

(Source: Added at 28 Ill. Reg. 11149, effective August 1, 2004)

Section 120.TABLE A Value of a Life Estate and Remainder Interest

Age	Life Estate	Remainder
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934
15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132
36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917

40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994
57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258
78	.47049	.52951
79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.40295	.59705

83	.38642	.61358
84	.36998	.63002
85	.35359	.64641
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000
99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

(Source: Added at 19 Ill. Reg. 2905, effective February 27, 1995)

Section 120.TABLE B Life Expectancy

Male		Female	
Age	Life Expectancy	Age	Life Expectancy
0	71.80	0	78.79
1	71.53	1	78.42
2	70.58	2	77.48
3	69.62	3	76.51
4	68.65	4	75.54
5	67.67	5	74.56
6	66.69	6	73.57
7	65.71	7	72.59
8	64.73	8	71.60
9	63.74	9	70.61
10	62.75	10	69.62
11	61.76	11	68.63
12	60.78	12	67.64
13	59.79	13	66.65
14	58.82	14	65.67
15	57.85	15	64.68
16	56.91	16	63.71
17	55.97	17	62.74
18	55.05	18	61.77
19	54.13	19	60.80
20	53.21	20	59.83
21	52.29	21	58.86
22	51.38	22	57.89
23	50.46	23	56.92
24	49.55	24	55.95
25	48.63	25	54.98
26	47.72	26	54.02
27	46.80	27	53.05
28	45.88	28	52.08
29	44.97	29	51.12
30	44.06	30	50.15
31	43.15	31	49.19
32	42.24	32	48.23
33	41.33	33	47.27
34	40.23	34	46.31
35	39.52	35	45.35
36	38.62	36	44.40
37	37.73	37	43.45
38	36.83	38	42.50

39	35.94	39	41.55
40	35.05	40	40.61
41	34.15	41	39.66
42	33.26	42	38.72
43	32.37	43	37.78
44	31.49	44	36.85
45	30.61	45	35.92
46	29.74	46	35.00
47	28.88	47	34.08
48	28.02	48	33.17
49	27.17	49	32.27
50	26.32	50	31.37
51	25.48	51	30.48
52	24.65	52	29.60
53	23.82	53	28.72
54	23.01	54	27.86
55	22.21	55	27.00
56	21.43	56	26.15
57	20.66	57	25.31
58	19.90	58	24.48
59	19.15	59	23.67
60	18.42	60	22.86
61	17.70	61	22.06
62	16.99	62	21.27
63	16.30	63	20.49
64	15.62	64	19.72
65	14.96	65	18.96
66	14.32	66	18.21
67	13.70	67	17.48
68	13.09	68	16.76
69	12.50	69	16.04
70	11.92	70	15.35
71	11.35	71	14.66
72	10.80	72	13.99
73	10.27	73	13.33
74	9.27	74	12.68
75	9.24	75	12.05
76	8.76	76	11.43
77	8.29	77	10.83
78	7.83	78	10.24
79	7.40	79	9.67
80	6.98	80	9.11
81	6.59	81	8.58

82	6.21	82	8.06
83	5.85	83	7.56
84	5.51	84	7.08
85	5.19	85	6.63
86	4.89	86	6.20
87	4.61	87	5.79
88	4.34	88	5.41
89	4.09	89	5.05
90	3.86	90	4.71
91	3.64	91	4.40
92	3.43	92	4.11
93	3.24	93	3.84
94	3.06	94	3.59
95	2.90	95	3.36
96	2.74	96	3.16
97	2.60	97	2.97
98	2.47	98	2.80
99	2.34	99	2.64
100	2.22	100	2.48
101	2.11	101	2.34
102	1.99	102	2.20
103	1.89	103	2.06
104	1.78	104	1.93
105	1.68	105	1.81
106	1.59	106	1.69
107	1.50	107	1.58
108	1.41	108	1.48
109	1.33	109	1.38
110	1.25	110	1.28
111	1.17	111	1.19
112	1.10	112	1.10
113	1.02	113	1.02
114	0.96	114	0.96
115	0.89	115	0.89
116	0.83	116	0.83
117	0.77	117	0.77
118	0.71	118	0.71
119	0.66	119	0.66

(Source: Added at 19 Ill. Reg. 2905, effective February 27, 1995)